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CDSBC | College of Dental Surgeons of British Columbia

Complaint Summaries

2014/15

Complaints: The Year 2014/15 in Review

The College of Dental Surgeons of BC (referred to below as CDSBC or "the College") closed 303 complaints for the fiscal year ending February 28, 2015:

- 51% were closed without any formal action required against the registrant (dentist, certified dental assistant, or dental therapist).
- 48% were closed on the basis of the registrant's agreement to take steps to address concerns identified during the investigation.
- 1% were referred to discipline.

Most complaints were made by patients or family members of patients; however, CDSBC also received complaints from dentists, other dental professionals, other health care providers and insurance companies.

Summaries of Files Closed with Action Taken to Address Concerns

Below are summaries of the complaint files closed with the registrant agreeing to take steps to address concerns raised in the investigation. These summaries are provided to educate the public, practitioners, and their staff on the types of complaints that CDSBC receives and how they are resolved. Specific and technical detail has been omitted from the individual case summaries to ensure understanding by a general audience.

Each complaint file summary contains a brief description of the nature of the complaint, information gathered during the investigation, and the agreed upon resolution. Identifying information about those involved has been removed.

Although the investigations are conducted by staff dentists (referred to as CDSBC Investigators in the summaries below), all complaints are accepted, directed, and closed under the direction of the Inquiry Committee. In each investigation, the Inquiry Committee reviewed an investigation report, decided the remedial action, and directed that the complaint file be closed pursuant to *Health Professions Act* section 36(1). Learn more about the complaints and discipline process >>

Many of the summaries mention that there will be monitoring to track compliance with the terms of the agreement. This typically refers to periodic chart reviews by CDSBC staff dentists to ensure the dentist being monitored is practising to an appropriate standard of care, but may also confirm that the registrant has

completed required courses. Depending on the issue, some of these monitoring files may remain open for several years after the complaint file is closed.

Health files
Files related to practitioner health (including addiction and mental health) are handled through the Registrar's Office, where possible, and not through the complaints/discipline process. CDSBC's wellness program ensures public protection while respecting a practitioner's personal dignity and providing for treatment and return to safe practice. Learn more about practitioner wellness >>

Notes about language

- Mentorship: this refers to a formal agreement for an experienced dentist to work with the dentist who is being monitored to improve the standard of care being provided. The agreement will specify the number of sessions or the length of time that the dentist will be mentored.
- Ethics course: this refers to the PROBE Canada (Professional, Problem-Based Ethics) program. This is an intensive multi-day ethics and boundaries course specifically designed to meet the unique needs of healthcare professionals. Intensive small group sessions target participants' unprofessional or unethical behavior, such as: boundary crossings, misrepresentations, financial improprieties, and other lapses.
- *Tough Topics in Dentistry*: this is a course offered by CDSBC to help dentists deal with the difficult situations they may encounter day-to-day. A major feature of the course teaches practitioners how to deal with requirements for informed consent (a concern identified in many of the complaint summaries). Informed consent means that the dentist: outlines all treatment options, risks, benefits and potential complications; provides a cost estimate and, if appropriate, a pre-determination from the insurer; is satisfied that the patient understands the treatment and agrees to it; and records discussions in the chart and/or a written treatment plan.
- Dental specialties (endodontic, prosthodontic, etc.): Many general dentists provide some of the services that fall within one of the 11 dental specialties. Examples include root canal treatment, orthodontics and pediatric dentistry. However, even if a general dentist performs a given treatment regularly, they may refer a patient to a certified specialist based on the dentist's assessment of a patient's individual oral healthcare needs. Read descriptions of dental specialties >>
- X-rays: for simplicity, this term is used to refer to a radiograph, the resultant image after a patient is exposed to an X-ray.

File 1	**Complaint** A patient complained that because the dentist poorly placed her implant (at an angle) it had to be replaced and that after she raised the issue with the dentist, she received a letter blaming her for the problem because she had not attended all of the follow-up appointments. **Investigation** The dentist said that the patient did not raise concerns about the placement of the implant at the four follow-up appointments, and believed that if she had an opportunity to evaluate the implant after it had healed, she would have been able to correct any shortcomings, even if it meant replacing it. The patient instead received independent reports from three other dentists who recommended the implant be removed and replaced, which the patient agreed to do under the care of a specialist. CDSBC Investigators were concerned that the dentist did not recognize the poor positioning of the implant. After reviewing patient charts, concerns remained regarding the dentist's implant competency, recordkeeping, and patient relations. **Resolution** The dentist signed an agreement to treat her patients professionally, take CDSBC's *Dental Recordkeeping* course, take courses in implant diagnosis and treatment planning, implant placement and implant complications, and receive mentorship and monitoring.
File 2	**Complaint** The wife of an elderly patient complained about the dentist's failure to complete a root canal procedure on one tooth and diagnose decay on another. **Investigation** The dentist explained that the patient's tooth needed root canal treatment, but she could not complete the procedure as one of the canals was calcified, making the procedure more complicated, and she could not locate the other canals. She told the patient to watch for signs of infection, and that if his symptoms returned, he would have to consider a referral to a specialist or have the teeth extracted. The dentist was unable to explain to CDSBC Investigators why decay on the second tooth was not diagnosed.

	When the patient's symptoms did not resolve, he sought a second opinion from another dentist who confirmed both teeth were fractured and needed to be extracted. The original dentist's records were incomplete, and the X-rays provided were not positioned in a way to allow for a proper diagnosis of the teeth. CDSBC Investigators were concerned by the dentist's apparent failure to diagnose decay beneath existing dental work, which was clearly evident on the X-rays. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, additional courses in X-ray technique and interpretation, and to either join an endodontic study club or take an endodontic course. The dentist also agreed to a chart review and monitoring.
File 3 Also see related: File 5	**Complaint** A patient questioned the dentist's diagnosis after her tooth fractured following a root canal and had to be extracted six weeks later. **Investigation** The dentist explained there was no evidence of a fracture when he saw the patient for a consultation. The dentist performed a root canal. A file tip separated and was left in one of the canals during treatment, but he did not tell the patient because he did not want to worry her unnecessarily. CDSBC Investigators could not confirm whether the tooth was fractured at the time the patient saw the dentist. They noted that the patient chart lacked detail and did not confirm informed consent discussions, nor that testing was done to confirm the diagnosis. **Resolution** Unrelated to this complaint, the dentist voluntarily withdrew from practice to deal with a health problem. The dentist has been advised that if he wishes to reinstate his registration, he will be required to sign an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and receive mentorship. Note: a patient must always be informed of an adverse event, such as a file separation, as well as the remedial options.
File 4	**Complaint**

	A patient complained that the dentist replaced a broken implant without waiting for the area to heal first, causing the new implant to fail. **Investigation** The dentist confirmed that the implant had to be removed after the post fractured, which was very difficult to do. The dentist told the patient about the complication, and the patient decided to have the implant replaced at that time. The patient attended three follow-up appointments, and the implant appeared to be healing well. However, when the patient left the country for an extended period, the area became infected and he had the implant removed by another dentist (while out of the country). The dentist noted that the manufacturer has since redesigned the implant she used, suggesting that the implant itself may have been a contributing factor to the problem. Despite the complications, there was no evidence of sub-standard treatment. CDSBC Investigators advised the dentist that she should have outlined all reasonable treatment options for the patient before proceeding. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* course.
File 5 Also see related: File 3	**Complaint** A patient complained about the dentist's root canal treatment when her symptoms did not resolve after treatment. **Investigation** The patient continued to experience pain and discomfort after two root canal treatments. Follow-up X-rays taken six months later showed concerns that should have been resolved by the treatment. One of the X-rays suggested a possible fracture. The dentist recommended monitoring the teeth to give them time to settle. The dentist agreed to consider re-treating the teeth if necessary, but he did not hear from the patient again. The patient instead saw a specialist, who successfully re-treated the teeth.

	In their review, CDSBC Investigators found concerns with the dentist's root canal diagnosis and treatment planning. **Resolution** Unrelated to this complaint, the dentist voluntarily withdrew from practice to deal with a health problem. The dentist has been advised that if he wishes to be reinstated, he will be required to sign an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and be mentored in endodontic diagnosis and treatment planning.
File 6	**Complaint** A parent questioned the dentist's billing protocols and recommendation that restorations be done on 16 teeth for each of her two teenage sons. Their regular dentist had not noted any issues six months earlier, and two other dentists had recommended monitoring rather than fillings. **Investigation** The dentist saw both boys for new patient examinations. He said his diagnosis was based on clinical findings and the use of a laser cavity detection aid. He showed their mother the findings and X-rays in support of his recommendation and told her that the treatment was to prevent decay from progressing. The dentist said that the mother did not object to the treatment and made a series of weekly appointments for her sons to be treated. The mother sought second opinions from two other dentists, who recommended monitoring the teeth rather than providing fillings. The dentist disputed his colleagues' opinions, as he felt the decay was irreversible and needed to be treated. Chart reviews revealed concerns related to recordkeeping, diagnosis and treatment planning, X-ray interpretation, restorations, and ethics (billing codes). **Resolution** The dentist signed an agreement to take an ethics course, CDSBC's *Dental Recordkeeping* course, and courses on diagnosing decay, treatment planning and X-ray interpretation, and to undergo monitoring.
File 7	**Complaint**

	A patient complained of nerve damage after the dentist placed two implants. She was left with paresthesia (extended numbness and prickling/burning sensation) on the right side of her tongue. **Investigation** The dentist confirmed that the patient phoned him to report a number of post-operative symptoms, including paresthesia. When these symptoms had not resolved within a week, the dentist discussed the possibility of nerve damage with the patient and referred her to a specialist, who suggested it might resolve on its own in time. Two years after the operation, the numbness on her tongue remained, which suggested that the condition is permanent. In discussing the complaint with CDSBC, the dentist expressed regret for what happened. He admitted that he was not happy with the positioning of one of the implants, which may have caused the trauma to the patient's nerve. Following a chart review of 10 implant cases, it appeared that this case was an isolated incident and not representative of the dentist's overall practice. CDSBC Investigators were however concerned about the lack of detail in the dentist's records. **Resolution** The dentist signed an agreement to ensure careful pre-surgical planning and to pay careful attention to the positioning of every implant. He also agreed to review CDSBC's *Dental Recordkeeping* Guidelines and take CDSBC's *Dental Recordkeeping* course.
File 8	**Complaint** A patient complained that the dentures he received did not fit, and that the dentist did not address his concerns. **Investigation** The dentist became involved in the patient's care after the dentist who had extracted the patient's teeth left the practice. The dentist said she had difficulty communicating with the patient and that there were times when he did not appear coherent. She says she explained the treatment to him, and although she was unsure if he understood what she was saying, she proceeded with it.

	Based on their discussions with the patient, CDSBC Investigators were satisfied that he understood the treatment and knew there could be a long period of adjustment. The patient chart confirmed the treatment plan and referenced informed consent discussions, but lacked sufficient detail. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and undergo monitoring.
File 9	**Complaint** A patient complained that he was charged more than the original cost estimate given to him. The patient refused to pay and the dental office referred the patient's debt to a collection agency. **Investigation** The patient received an estimate of $150 to restore two teeth. After treatment began, the dentist realized more surfaces needed to be restored for the teeth to be functional, but he did not tell the patient about the change in treatment plan, nor that the cost would be $250 more. The dentist's records confirmed the rationale for the change in the treatment, but showed inconsistencies in the office's communication with the patient. CDSBC Investigators advised the dentist that after the treatment plan changed, he no longer had the patient's informed consent. **Resolution** The dentist signed an agreement to take CDSBS's *Tough Topics in Dentistry* course. CDSBC does not have authority to become involved in a fee dispute, so the financial-based component of the complaint cannot be addressed by the College. It is a civil matter between the patient and the dentist.
File 10	**Complaint** A patient complained of problems following implant surgery that made it difficult to eat, including gaps under her bridges and misalignment between her top and bottom teeth. **Investigation** The patient initially wanted the dentist to address her dissatisfaction with her existing upper denture by making a bridge, but later agreed to his recommendation of an implant-supported upper denture. On the day of the surgery, the patient changed her mind and stated that she wanted implant-

	supported bridges instead. The dentist said she explained to the patient that this went against her recommendation but ultimately agreed to change the treatment plan. The dentist said a new cost estimate was given to the patient when the treatment plan changed, but no copy was kept on file. The records lacked other important information, there were inadequate pre-operative X-rays, and no post-operative photographs or X-rays taken. CDSBC Investigators determined the dentist's recordkeeping and informed consent protocols were not up to standard. Due to the patient's deteriorating medical status, it was not possible to assess the standard of care in relation to the implant-supported bridges. **Resolution** The dentist signed an agreement to take a course in X-ray interpretation, CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and undergo monitoring.
File 11	**Complaint** A patient complained after the dentist replaced her partial upper denture with a bridge. The patient said this was not an improvement from what she had before, and that the bridge fell off after only two years. **Investigation** The patient thought that she would no longer have a denture after the treatment. The dentist said that the patient was given a number of treatment options and consented to a complex treatment plan that involved both bridgework and a new partial upper denture. He acknowledged that the patient seemed overwhelmed during the conversation, but that he thought she had consented and had a good understanding of the treatment. For such a complex case, the patient chart lacked detail. It did not include a written treatment plan, study models, or reference to informed consent discussions or other interactions with the patient. The dentist thought the problem with the bridge was due to the patient's irregular dental cleaning and hygiene, which in turn caused gum problems. However, there was no indication in the chart that the patient was advised of this. **Resolution**

	The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, join a prosthodontics study club and undergo monitoring and a chart review.
File 12	**Complaint** A patient complained that the dentist gouged his gums during treatment and had a terrible chairside manner. **Investigation** The dentist said that while replacing an old filling, the dental wedge broke into pieces, which was unusual. The patient experienced discomfort as the dentist attempted to remove it piece by piece. The dentist said she did explain to the patient what she was doing, and this was supported by the records. When the pain worsened, the patient saw a different dentist, who confirmed that not all of the pieces of the wedge had been removed. The pre-operative X-ray of the tooth did not show any decay, which raised concern about the dentist's X-ray interpretation. The dentist agreed to a chart review, which found similar issues in three of five charts. CDSBC Investigators also found concerns with the dentist's recordkeeping and informed consent protocols. **Resolution** The dentist signed an agreement to take a course in X-ray interpretation and CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to undergo monitoring.
File 13	**Complaint** A patient complained that the dentist filled five teeth when he was only supposed to fill one. This used up the patient's insurance, leaving him to pay out of pocket for a later root canal treatment. **Investigation** The dentist confirmed that following a new patient examination, he had recommended fillings on five of the patient's teeth. The dentist says this was discussed with the patient following the examination and at the next appointment.

	X-rays taken by another dentist showed that three of the five fillings were failing. The treating dentist acknowledged that the work was not his best and he would have redone it if the patient had returned to his practice. A review of the patient chart revealed concerns with the dentist's recordkeeping and informed consent protocols, as well as diagnosis of decay and restorative treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and take courses in restorative treatment and decay management. The dentist also agreed to monitoring and a chart review.
File 14	**Complaint** A patient complained that the dentist misled her about the results of Botox® and dermal fillers. **Investigation** The patient was unhappy with her appearance after the dentist applied too much dermal filler above her lip. She was given injections to dissolve it, which did not work. The patient was unaware that it is outside the scope of a general dentist in B.C. to administer dermal fillers. The dentist said she did not mislead the patient and provided CDSBC Investigators with signed consent forms, which showed how long the results of each procedure might last. The dentist said that the Botox® and dermal fillers were administered outside of the dental office in a separate spa setting, and were overseen by a physician. She challenged CDSBC's authority to restrict the practice of general dentists in this way and did not feel that CDSBC could regulate her conduct outside of the dental office. The dentist later acknowledged that it is outside the scope of practice for general dentists to directly administer dermal fillers, regardless of whether the procedure was supervised or where it was carried out. **Resolution** The dentist signed an agreement not to administer or advertise the administration of dermal fillers.

File 15	**Complaint** The parent of a patient who had surgery to reposition his jaw reported that her son experienced airway and swallowing difficulties following surgery, which led to him being rushed to the emergency room (ER) and then hospitalized for an extended period. The parent complained that the dentist did not provide detailed post-operative instructions. **Investigation** The dentist said that the surgery was explained in detail at several consultations with the patient and his father. The patient's father signed a consent form to this effect, and the dentist felt he understood what was involved. The dentist said he provided the father with post-operative instructions and showed him how to cut the elastics that were holding the patient's teeth together in the event that the patient developed breathing problems or had difficulty swallowing. The dentist noted that when the patient experienced these problems, the family did not cut the elastics as instructed to allow the patient to breathe through his mouth, and instead rushed him to the ER, where the on-call physician performed a tracheotomy. The dentist expressed frustration that he was not contacted and believed the post-operative problems were a result of the tracheotomy. The dentist's records supported the rationale for the treatment, but the chart lacked detail about the consultations with the patient and his father. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and to provide patients with written information that ensures they understand the treatment and have clear expectations. A monitoring file was opened to track the dentist's compliance.
File 16	**Complaint** A patient complained that he experienced numerous problems with extensive treatments provided by the dentist. Five other dentists agreed that all of the treatment provided by the dentist needed to be redone. **Investigation** The dentist said that she was unaware of the problems because the patient did not raise any concerns with her at the next appointment, and none of the five dentists who later treated the patient had contacted her. The dentist

	said that when the patient eventually contacted her, she offered to re-do the work, but he declined. The records provided by the dentist revealed numerous concerns with the quality of her work. The post-operative X-rays showed poor results, which the dentist had failed to recognize. A random chart review showed a pattern of sub-standard work. **Resolution** The dentist signed an agreement to join a restorative study club, to have another dentist supervise her crown and bridge dentistry until it is deemed acceptable, and to undergo significant mentorship and monitoring.
File 17	**Complaint** A patient complained that a crown placed by the dentist was causing him pain, and that the dentist refused to speak with him when he returned to complain about the pain. **Investigation** The patient received a temporary crown from the dentist to fix a gap. It fell out after only one day, but the patient did not let the dentist know until he returned a week later to receive the permanent crown. The patient experienced sensitivity on the tooth when the temporary crown fell off, which the dentist attributed to his heavy bite. The dentist said that the patient told him that the sensitivity was only occasional, so he inserted the permanent crown, believing that the tooth would settle over time. The patient said that he later returned in pain, and the dentist walked out of the operatory and refused to return his calls. The patient reported that he experienced problems for two years. The dentist later contacted the patient and offered a refund before retiring from the profession. The patient accepted the refund and had the crown successfully replaced. A review of the patient chart showed that despite the patient being seen regularly for 25 years there was insufficient records, with no health history and only one X-ray. There was nothing to confirm the dentist's diagnosis and treatment planning, nor informed consent discussions. **Resolution** The dentist is now retired, but if he wishes to return to practice, he will be required to sign an agreement to take CDSBC's *Dental Recordkeeping* and

	Tough Topics in Dentistry courses and courses related to diagnosis and treatment planning.
File 18 & File 19	**Complaint** Following an audit, a dental insurer reported concerns about the billing practices of two dentists (File 18 & 19). The insurer noted that in each case, the dentist billed excessive amounts for a patient with unlimited dental coverage, compared to his/her usual fees for the same procedure. Because of the patients' plans, the dentists were able to use the insurer's automated telephone system to automatically be approved for full payment on two separate charges for a root canal procedure. **Investigation** The investigation of both cases was very similar. In each, the investigation raised concerns about inaccurate billing codes and recordkeeping. Each of the two dentists said his/her staff have the discretion to bill according to the complexity of the procedure, his/her expertise and the length of time involved. In both cases, the dentist felt a higher bill was reasonable given that the procedure took longer than usual, but CDSBC Investigators questioned whether the additional billing was in line with the extended length of the treatment. In each case, the dentist said that he/she had not seen the billing in question but that he/she had reimbursed the insurer. **Resolution** Each dentist acknowledged the ethical issues with his/her billing practices and agreed that it was his/her responsibility to oversee and ensure the accuracy of the billing process. Each dentist signed an agreement to complete an ethics course, undergo monitoring and chart reviews, review the *Dental Recordkeeping Guidelines*, and take CDSBC's *Dental Recordkeeping* course.
File 20	**Complaint** A patient complained that the dentist placed a crown on a split tooth without performing a root canal first. This led to the crown needing to be replaced when root canal treatment was later necessary. The patient did not believe he should have to pay for this but the dentist did not respond to his phone messages. **Investigation**

	The dentist crowned a split tooth in the hopes of avoiding the need for root canal treatment. He said that he told the patient that root canal treatment might later be necessary. The dentist did not notice that he left extra cement at the edge of the crown when it was placed. This was noted by another dentist at the practice, who recommended replacing the crown. The original dentist left the practice and did not know that the patient was trying to reach him. The dentist later saw the patient at his new practice, where he replaced the crown at no charge. CDSBC Investigators were concerned that the dentist did not recommend root canal treatment earlier, since the tooth was sensitive. It appeared that the patient had not been given all of the available treatment options. The dentist was receptive to the feedback. He said that while this case was an isolated incident, he had taken extensive continuing education in endodontic and prosthodontics diagnosis and treatment planning to improve his skills since receiving the complaint. **Resolution** CDSBC Investigators confirmed that the dentist took several courses which sufficiently addressed the concerns raised by the patient's complaint.
File 21	**Complaint** A patient complained that she experienced ongoing discomfort after having a number of crowns placed by the dentist. His attempt to adjust the patient's bite did not resolve the discomfort. The patient sought a second opinion, and learned one of the crowned teeth had a hole and the tooth needed to be extracted. **Investigation** The dentist confirmed that the complainant had been his patient for a decade, during which he placed crowns and provided root canal treatment. The records confirmed the treatment but did not contain sufficient detail of his diagnosis and treatment planning. It was also noted that no X-rays had been taken following treatment. The records provided by the second dentist confirmed a hole in the tooth, requiring it to be extracted. They also showed gaps on other crowns. After reviewing the X-rays, the treating dentist acknowledged the hole but did not agree that the tooth was unsalvageable.

	Resolution The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, as well as take clinical and hands-on courses in endodontics and prosthodontics, followed by a chart review and monitoring.
File 22	**Complaint** The patient complained about the orthodontic treatment of a certified specialist after two of his teeth were declared 'dead' and required root canals following two years of treatment to close a space between his teeth. **Investigation** The patient was initially treated by a general dentist for two years of orthodontic treatment. The general dentist had advised against attempting to close a space left between the teeth and instead recommended that an implant be placed at a later time. He referred the patient to an orthodontic specialist. The specialist told CDSBC Investigators that he accepted the patient referral because he assumed the space between the teeth could be closed. While there was some small movement initially, after a year of treatment it was clear that the space could not be closed any further as the teeth appeared to be fused to the bone. Despite this, the specialist did not remove the patient's braces for another year. He could not explain to CDSBC Investigators why this took so long. The patient chart did not show that the teeth had been tested before treatment began to check if they were fused to the bone. The specialist did not believe there was any correlation between the orthodontic treatment and the need for root canals. The records confirmed that the patient played contact sports and could have suffered a blow to the face that would cause him to need root canal treatment. CDSBC Investigators were concerned that the specialist's records did not support the rationale for orthodontic treatment and did not include sufficient detail of informed consent discussions with the patient and his parents, including the possibility of an unsuccessful outcome. **Resolution** The specialist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.

File 23	**Complaint** A patient with multiple medical conditions complained that she experienced chest congestion, exhaustion, and difficulty sleeping and eating following root canal treatment. **Investigation** The patient had undergone similar treatment in the past and the dentist felt she knew what was involved. The patient would often cancel appointments on short notice if she didn't feel up to it. In this instance, the dentist said that it was the patient who made the appointment for the root canal, as she wanted the work completed before going on vacation. The patient's health history indicated that she bruised easily and suffered from asthma, arthritis, and lung congestion. The dentist said she updated the medical history at each appointment, but the chart did not show medical history updates between 2007 and 2011. There was no evidence that the patient's symptoms were connected to her dental treatment. The chart did not reference informed consent discussions with the patient, and did not include details of diagnosis and treatment planning. **Resolution** The dentist signed an agreement to review CDSBC's *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 24	**Complaint** After undergoing unsuccessful gum grafting surgery, a patient complained that the dentist did not fully explain the procedure beforehand and that the bill did not match the estimate. The patient said that the dentist initially offered to re-do the surgery at no charge but later said she would be billed. The patient declined to have the surgery again and requested a refund, which the dentist said he would provide only if the patient signed a release. **Investigation** The dentist said that the surgery was discussed with the patient and she understood that he would determine the areas to be treated once surgery was underway. The patient had received an estimate for two teeth but four were grafted. He said that the treatment seemed to be successful, and that he removed the stitches at the follow-up appointment. When the patient returned two weeks later, he noted the gum had thinned and suggested the surgery be redone.

	A review of the patient chart raised concerns about diagnosis and treatment planning, recordkeeping, informed consent, patient management and the standard of his gum procedures. Neither the patient's new dentist, nor a specialist he referred her to, saw any evidence that the grafts had ever been done. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, to take a course focused on periodontal diagnosis and treatment planning, and to be mentored by another dentist. He also agreed to undergo monitoring and a chart review.
File 25	**Complaint** The parents of a 10-year-old complained that a dentist recommended nine fillings, whereas another dentist concluded that no fillings were needed. **Investigation** The dentist said his recommended treatment was based on a clinical examination, X-rays, and the family's history of decay and poor oral hygiene. The pre-treatment estimate was based on a worst-case scenario and the dentist said that he had explained to the parents that not all of the treatment was required. However, it was clear to CDSBC Investigators that the family did not understand that the recommended treatment was a preventive approach. **Resolution** As a result of the complaint, the dentist and his staff took CDSBC's *Dental Recordkeeping* course and made other treatment planning improvements, including ensuring that patients are given all treatment options and understand that his estimates are based on worst-case scenarios. CDSBC was satisfied that the steps already taken by the dentist addressed the concerns raised by the patient's parents.
File 26	**Complaint** The parent of a four-year-old patient complained that the dentist failed to diagnose an abscess on the child's front tooth following a fall. The parents said that even though their child was in pain, the dentist only recommended monitoring the tooth. The parent took the patient to see a specialist, and was told that the X-ray taken by the first dentist clearly showed an abscess. The specialist extracted the tooth.

	Investigation The dentist confirmed that he had taken a conservative approach and did not feel that the tooth needed to be extracted as there was no evidence of swelling. The dentist acknowledged the child did attend numerous times reporting pain, but he still did not feel removing the tooth was necessary and recommended more monitoring. A review of the records and the patient chart raised concerns about the dentist's X-ray interpretation, recordkeeping and informed consent protocols. There was no detail concerning the discussions he said he had with the parent about treatment options. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, courses in X-ray interpretation and pediatric trauma, and to undergo a chart review after the coursework is complete.
File 27	**Complaint** A patient complained about the quality of a root canal performed by her dentist after severe pain and swelling did not go away until the tooth was re-treated by a specialist nine months later. **Investigation** The patient attended the dental office in severe pain. The dentist diagnosed inflammation of the dental pulp tissue and performed root canal treatment that same day. There was no evidence of swelling or tenderness, so the dentist told the patient that she should feel better the next day; he did not prescribe medication. The pain continued the following day, so the patient called the dentist, who gave her a prescription for antibiotics. She had an allergic reaction to the antibiotics and was treated in hospital, where she was given a different medication and was told the tooth was abscessed. A review of the patient chart confirmed that the tooth was not abscessed at the time the dentist performed the root canal. However, there were deficiencies in the dentist's root canal treatment. The tooth had an unusual structure and the dentist missed treating some of the canals, while the ones he did treat were not properly filled. **Resolution** The dentist signed an agreement acknowledging the concerns about his root canal treatment competency and confirming he had proactively taken a

	CDSBC-approved course to improve his knowledge and skills in this area. CDSBC was satisfied that this addressed the concerns raised by the complaint.
File 28	**Complaint** A patient complained that despite attending regular hygiene appointments, the dentist failed to manage her gum disease, which eventually required extensive treatment under the care of a certified specialist. **Investigation** In light of the patient's family history of gum disease, the dentist recommended she have hygiene appointments every six months. She only attended twice over three years, however, and the condition worsened. The dentist recommended the patient attend every three to four months, which she did for 18 months. The dentist concluded the patient's condition was not improving, and he referred her to a specialist, who recommended surgery. The patient cancelled the surgery because she had no dental coverage. She then moved away, telling the dentist and specialist that she would seek treatment in her new city. The patient returned to the dentist two years later, and had not had the surgery or any treatment. As the gum disease had further progressed, the dentist again referred the patient to a specialist. The dentist was not able to provide the complete patient chart, as his office had switched software, causing some of the earlier records to be lost. The chart provided did support the dentist's response but the diagnosis was not recorded, nor were there sufficient details of the dentist's treatment planning sessions with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and undergo a chart review.
File 29	**Complaint** A patient complained that she was advised that she needed fillings on three teeth, but when she returned to have the treatment done, she saw a different dentist who changed the treatment plan without telling her, and filled 11 teeth. **Investigation**

	The treating dentist explained that the patient had initially been seen and diagnosed by a recent graduate who had a very conservative approach to treatment. She advised that her next clinical examination revealed the need to restore all 11 teeth, although it was not clear from the X-rays whether all of the restorations done were necessary. The dentist said she had discussed the change with the patient, but acknowledged that she should have provided the patient with a written treatment plan advising of the change. The patient says she was never told of the change in the treatment plan and only became aware when there was a question about whether her insurance would cover the treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, an X-ray interpretation course, and undergo a chart review.
File 30	**Complaint** A patient complained that the dentist did not take her bite into consideration before making a new fixed upper denture, and that he was unable to fix issues with it despite a number of adjustments. **Investigation** The patient saw the dentist to have the denture made after having six implants placed by another practitioner. The dentist said he did his best to resolve the problems experienced by the patient, but could not explain why the denture kept fracturing, as he had made a mouth guard for the patient that would protect the denture from her bite. The patient said the dentist offered to fix the issue by providing a removable denture, but that she declined as she would have to pay $5,000 in lab costs. CDSBC Investigators found that given the complexity of the treatment plan, the dentist should have referred the patient to a prosthodontics specialist. A review of the records revealed concerns related to recordkeeping, informed consent and prosthetic diagnosis and treatment planning. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course. He also agreed to undergo mentoring and a chart review.
File 31	**Complaint**

	A university student complained that after the dentist replaced a broken filling, she experienced severe pain and a “dead tooth,” requiring a root canal and crown. The patient’s dental insurance had been exhausted by seven other fillings done by the dentist, and she had to pay for the treatment herself. **Investigation** The dentist had done a number of fillings, including replacing a filling on a tooth that had deep decay. The dentist said she told the patient that the filling was close to the nerve and might require a root canal in the future. The records supported the treatment on the tooth in question, and there was no evidence of sub-standard treatment. However, billing inconsistencies were noted and the patient chart was incomplete, making it difficult to determine the rationale for the other seven fillings. There was also an informed consent concern because the patient said she had not been told of the cost or treatment options ahead of time. **Resolution** The dentist signed an agreement to take CDSBC’s *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 32	**Complaint** A patient complained that she had received unnecessary treatment after her new dentist questioned why she had an unusually high number of root canal-treated teeth. The patient thought that all crowned teeth needed root canals. **Investigation** The original dentist denied telling the patient that all crowned teeth needed root canals and said that a diagnosis would be based on the patient’s symptoms, the results of testing, and a review of the X-rays. The patient chart showed a high number of root canal-treated teeth though there was no indication that the patient had been told that root canal treatment goes hand-in-hand with crowns. In some instances the chart supported the recommendation for root canal treatment, but in other cases no notations were made to confirm how the diagnosis had been made. The patient had a history of grinding; her teeth showed extensive wear and she had received three night guards over the years.

	The records raised a concern about the quality of the dentist's root canal treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and either take a hands-on endodontic course or join an endodontic study club, followed by a chart review and monitoring.
File 33	**Complaint** The father of a teenaged orthodontic patient complained that after two years of braces, the treatment objectives had not been met. **Investigation** The dentist agreed that treatment objectives had not been met, but stated that this was because the patient had missed 10 appointments, broken her braces seven times, and often removed brackets herself. The dentist spoke to the patient about the importance of compliance on five separate occasions. She felt pressured by the father to continue with the treatment but eventually recommended that treatment be discontinued until the patient was more mature. The patient's braces were removed and retainers made for her. The records supported the treatment rationale, and post-treatment photographs showed improvement, although it was clear that the treatment was incomplete. The only concern arising out of the complaint related to the dentist's recordkeeping: the patient chart was at times illegible and did not contain sufficient detail of the dentist's informed consent discussions and other interactions with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course followed by a chart review and monitoring to re-assess her recordkeeping.
File 34	**Complaint** A patient complained that the dentist and her staff failed to recognize the symptoms of a life-threatening allergic reaction to anaesthetic that she was given at a dental appointment. **Investigation** The dentist said she had reviewed the patient's medical history and there were no known allergies recorded. The patient seemed nervous after the

	injection and told the dentist that she was likely having an anxiety attack but still wanted to proceed with treatment. The treatment was uneventful and the patient did not exhibit any signs typically associated with anaphylactic shock. The patient went to her doctor later that day. He said that her airways were clear and her vital signs were normal; however, he gave her Benadryl and epinephrine and sent her to the emergency room (ER), where she was observed and released. The ER physician noted that the patient's symptoms had resolved by the time she arrived, and the allergy specialist confirmed that the patient had likely experienced a reaction to the anaesthetic combined with anxiety. The dentist confirmed that she and her staff were trained to recognize and respond to acute allergy symptoms and that since receiving the complaint she had taken a CPR course for healthcare professionals and another course on how to respond to medical emergencies. A review of the patient's chart showed insufficient detail of the dentist's interactions with the patient following the treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course.
File 35	**Complaint** A patient complained that the dentist should have been more involved in her care to reduce post-operative problems. The patient believed that the certified dental assistant (CDA) was not skilled enough to install a permanent crown, and said that the dentist did nothing but recommend painkillers. **Investigation** The dentist placed an implant right after extracting a tooth. While it appeared to be healing well at first, it later failed, which the dentist believed was caused by the patient not following the post-operative care instructions. He replaced the implant at no charge. The dentist said that the CDA placed the permanent crown to check the colour and aesthetics with the patient but that he performed the actual installation. This was a concern because CDAs are not permitted to place

	("try in") permanent crowns. Three different dentists who all later treated the patient confirmed an excellent result had been achieved. The investigation found that none of the recorded entries were initialed, making it difficult to determine who authored the entry and who performed the treatment. **Resolution** The dentist agreed to take CDSBC's *Dental Recordkeeping* course and ensure his CDAs would only perform procedures outlined in CDSBC's *Guide to CDA Services*.
File 36	**Complaint** A patient complained that the dentist refused to re-cement his loose bridge and instead recommended unnecessary treatment. **Investigation** Following two X-rays and an exam, the dentist diagnosed deep decay on a tooth supporting the patient's bridge. The dentist was not comfortable re-cementing a bridge over a decayed tooth as he thought it was sure to fail, so he outlined a number of other treatment options. The patient said he thought the dentist was taking advantage of him and left without receiving any treatment. The patient visited another dentist, who also noted the deep decay and recommended the bridge be replaced. At the patient's insistence, he removed the decay and re-cemented the bridge. The patient chart supported the original dentist's rationale for the diagnosis and treatment options given to the patient; however, it did not contain sufficient detail of the treatment options or the dentist's interactions with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course.
File 37	**Complaint** A longstanding patient questioned the dentist's recommendation to replace three crowns and felt that a poor fit on the crowns had caused decay. **Investigation**

	The dentist diagnosed decay under three crowns and recommended that they be removed to allow him to remove the decay before replacing them. The patient had a long history of difficulty maintaining good oral health and saw the dentist every four months. At every visit, the patient had inflamed gums, bleeding, sensitivity and plaque. The dentist believed the decay developed as a result of the patient's hygiene habits and the side effect of a medication that caused dry mouth. The dentist said she explained this and thought the patient understood the rationale for the recommended treatment. The patient chart supported the rationale for the treatment plan, included the hygienist's instructions to the patient about good hygiene habits, and showed that there were no issues with the placement of the crowns. The diagnosis was further supported by records provided by a certified specialist that the patient had seen. The patient's history was well documented overall; the only concerns were related to a lack of detail about informed consent discussions and whether the dentist had told the patient that a separated file tip had been left in a tooth after root canal treatment. **Resolution** The dentist agreed to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 38	**Complaint** The parent of a teenaged patient complained that the dentist restored a tooth without informing the patient, and that she caused her pain by not using anaesthetic. **Investigation** The dentist decided to restore the tooth at the appointment after noticing a small amount of decay. She did not tell the patient and did not use anaesthetic because she did not believe that removing a small amount of decay would cause pain. The dentist noticed the patient appeared to be uncomfortable, but when she asked if she was okay, she nodded her head. The patient said that she did not admit she was in pain because she did not want to complain. CDSBC Investigators were concerned that the dentist did not appear to understand what constitutes informed consent. The dentist could not explain why she did not wait to restore the tooth until she had informed

	consent from the patient or parent to proceed. The patient chart supported the dentist's diagnosis, but did not reference the incident or the change in treatment plan until after the patient's mother called to discuss it. Finally, it was not clear whether her billing accurately reflected the treatment provided. **Resolution** The dentist agreed to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses and to ensure that her billings accurately reflect the treatment provided.
File 39	**Complaint** A patient complained about the failure of two implants placed by the dentist after they were replaced successfully by another dentist. **Investigation** The patient's sutures fell out almost immediately following the placement of the two implants, and then again three more times in the following days. She did not receive Ativan as promised by the dentist prior to the surgery. The two implants failed and were removed. The dentist suggested that the failure was because the patient picked at the sutures and did not follow post-operative instructions. The patient had signed a consent form, but it was a generic form that did not include information about implants or list any risks associated with the procedure. When the dentist removed the implants, he told the patient she was not a good candidate for implants and recommended a bridge. A different dentist later successfully placed implants. The chart did not confirm the post-operative discussions the dentist claimed to have had with the patient, and did not confirm the dentist's assertion that Ativan was given. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. He also agreed to take a hands-on course focused on implants, followed by monitoring.
File 40	**Complaint** The parents of an orthodontic patient complained that the treatment led to a "dead tooth," which turned black over a short period of time.

	Investigation The parents consulted with the dentist about orthodontic treatment for their son, but did not make a decision until a year later. Then, seven months after treatment began, the parents brought their son in, noting that one of his front teeth was slightly darker. The dentist referred the patient to a number of other dentists, and the parents also arranged for their son to see additional dentists of their choice. The reports from those dentists suggested that the death of the tooth was not related to the orthodontic treatment, and was probably a result of trauma suffered within the previous two to three years. The parents felt these opinions were biased and accused the dentist of trying to hide his mistake. The patient chart supported the treatment rationale, but the records were not in chronological order and one of the free consultations was not recorded. The dentist said that because the parents took a long time to decide whether to proceed with treatment, he did not give them a detailed booklet explaining the potential complications and risks of treatment. The dentist did not ask the patient or his parents to sign consent forms before initiating treatment, believing it to be an uncomplicated case. **Resolution** The dentist agreed to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 41	**Complaint** A patient complained about tingling and numbness in his lip and cheek after receiving freezing, and that the dentist was unapologetic about the symptoms. He also expressed concern about hygiene, noting dust on the base of a chair and that the dentist did not wear a mask. **Investigation** The patient experienced a prickly feeling at the corner of his mouth because the needle was close to the nerve. The dentist said he saw the patient several times over the following weeks and that the patient reported improvement in the symptoms at each appointment. The dentist felt he was interested in the patient's condition and said that he and his staff made every effort to reassure the patient that the condition would improve over time, which it did.

	The dentist admitted that he did not usually wear a mask because he found them uncomfortable and they caused his glasses to fog up, making it difficult to see. The records supported the rationale for the treatment undertaken but the treatment notes lacked detail and some were out of order. There was no indication in the chart that the patient's significant medical history was discussed at his appointments to ensure there were no health issues that might interfere with the treatment. **Resolution** The dentist was advised that while wearing masks is not mandatory, it is strongly recommended in the *Infection Prevention and Control Guidelines* and it was suggested he try different brands to find one that did not fog up his glasses. The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course.
File 42	**Complaint** The mother of a teenaged patient complained that the dentist caused her daughter pain by not removing all the decay when she restored one of the patient's teeth. She was also shocked that the dentist had charged about $850 for a 40-minute appointment. **Investigation** The patient received a new patient exam. After taking a series of X-rays, the dentist restored five teeth and then did a cleaning. The patient was in pain afterwards, so the mother took her to a nearby dental office for a second opinion, where they learned that there was still decay under one of the restorations just completed. The records lacked detail. No informed consent discussions were recorded and the dentist admitted she proceeded with the restoration work without outlining the treatment options to the patient. The dentist said that she saw the patient for about an hour, but the billing suggested treatment that would have taken longer. The dentist said she did not understand aspects of the BC Dental Association *Suggested Fee Guide* and reimbursed the patient's insurer. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and *Tough Topics in Dentistry* courses, take a tooth decay

	management course, bill in accordance with the *Suggested Fee Guide*, and undergo monitoring and a chart review.
File 43	**Complaint** A patient complained that after receiving a removable partial denture to replace a loose bridge she experienced ongoing discomfort that the dentist could not resolve. **Investigation** The patient's bridge was loose and she was concerned about a loose supporting tooth. The dentist noted problems with many other broken teeth that were unsalvageable. The broken teeth were extracted and the bridge was replaced with a removable partial denture. The dentist said the patient appeared happy with the denture and that only one adjustment needed to be made. The patient chart did not meet the expected standards and lacked detail about the treatment plan. It also raised concerns with the dentist's diagnosis and treatment planning, as he did not seem to recognize that the supporting tooth would not be able to hold the denture, and did not seem to note bone loss that was visible on the X-rays. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and to take courses or join study clubs focused on diagnosis and treatment planning of gum disease and removable partial dentures, followed by monitoring and a chart review.
File 44	This file required public notification. Read the publication notice: Yu Li >>
File 45	**Complaint** A patient complained that the dentist was not attentive to her concerns when she reported ongoing tooth sensitivity, swelling, and bruising after four teeth were restored. **Investigation** The dentist first saw the patient at an emergency appointment for a broken filling. He noted other dental issues and asked her to return for a new patient examination. At the exam eight days later, the patient did not mention any sensitivity or pain, and there was no evidence of bruising or swelling.

	At the next appointment to restore a number of her teeth, the patient was quiet and appeared to the dentist to be relaxed. After the treatment was finished, however, she became teary and upset. The dentist saw the patient again to adjust some of the fillings. The patient brought a letter with her outlining concerns of tooth sensitivity and swelling, but said that her teeth were settling down. The patient disagreed with the dentist's suspicion that the problems might be caused by her grinding her teeth. The dentist said he tried to answer the patient's questions, but that he ended the conversation when she raised issues not related to her treatment. The patient chart did not include any detail of his discussions with the patient, nor was there any indication of any informed consent discussions. **Resolution** The dentist is now retired, but if he wishes to return to practice, he will be required to sign an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 46	**Complaint** Dentist B complained about the quality of crowns that were provided by Dentist A, expressing concern about fit, evidence of decay, and other issues related to the standard of care. **Investigation** Dentist A had seen the elderly patient for over 30 years. She had a long and complicated medical and dental history. Her various conditions had led to a compromised immune system that also affected her oral health. Dentist A replaced many old crowns placed by a previous dentist. Many of the teeth were also root canal-treated, two of which had fractured and needed to be extracted. Dentist A used an alternative material to fill the canals and agreed that it may have led to the fractures. Dentist A acknowledged concerns raised by CDSBC Investigators about his recordkeeping and root canal treatment diagnosis and planning, but felt that Dentist B should have contacted him directly with the concerns, so that he could have explained how the dental and medical history contributed to the patient's current oral health status.

	Resolution Dentist A signed an agreement to take CDSBC's *Dental Recordkeeping* course, complete a hands-on root canal treatment course, join a prosthodontics study club and undergo a chart review and monitoring.
File 47	**Complaint** A patient complained that he experienced numbness after the dentist extracted all four of his wisdom teeth and left behind tooth fragments. The patient saw another dentist, who removed the fragments and told him that only one of the wisdom teeth had needed to be removed. **Investigation** The dentist said he had consulted with the patient about how many wisdom teeth to remove, and the risks involved, and the patient had decided to have all of them removed. During the removal, some nerve damage was caused either by the tooth being close to the nerve, or from the anaesthetic. The dentist informed the patient that root tips were left behind, and scheduled an appointment to remove them. When the patient came back to the office, staff were running behind so he left and saw another dentist to have the root tips removed (the first dentist paid for the treatment). The patient chart did not reference informed consent discussions and did not support the rationale for removing all of the wisdom teeth. Concerns were also identified with the dentist's diagnosis and treatment planning. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, review the *Minimal and Moderate Sedation Services in Dentistry* Standards & Guidelines, take two courses in surgery for impacted third molars and extractions, and undergo a chart review and monitoring.
File 48	**Complaint** The mother of a patient complained about the outcome of orthodontic treatment her son received from the dentist. She said that there were gaps between some of his teeth and the dental composites used during treatment caused gum inflammation and were difficult to clean. **Investigation**

	The dentist said that the majority of the gaps in the patient's teeth were closed at the end of treatment. The patient was fitted with a lower retainer and the dentist believed that the remaining gaps would close naturally. He offered the patient alternative options to close the gaps, but his mother took him to another orthodontist instead. The patient chart supported the dentist's treatment plan and the fact that he achieved a good result, although it was not what the patient had expected. A review of the patient chart raised concerns about the dentist's recordkeeping and informed consent protocols, as the dentist did not provide a written treatment plan or cost estimate, and no progress reports were given to the patient's parent, who did not attend appointments with her son. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* course and provide all orthodontic patients with written treatment plans and updates throughout treatment.
File 49	**Complaint** A complaint was made about promotional activity on the dentist's website, which advertised instructional courses to dentists on the administration of Botox® and dermal fillers. **Investigation** The dentist voluntarily made changes to his website to address the promotional activity concerns, but challenged CDSBC on its position that the administration of dermal fillers is outside general dentists' scope of practice. CDSBC Investigators explained the College's policy to not allow general dentists to administer dermal fillers. **Resolution** The dentist signed an agreement not to administer dermal fillers, to follow the CDSBC bylaws and guidelines on advertising and promotional activities, and to add a disclaimer on his website stating that the administration of dermal fillers is outside of the scope of practice for general dentists in B.C.
File 50	**Complaint** The mother of two teenage patients complained that the dentist did not consult her before beginning treatments that were not fully covered by her dental plan.

	Investigation The dentist consulted with both patients about their wisdom teeth, but noted that another associate in the office was their regular dentist. He recommended no treatment for one daughter, and extracting two wisdom teeth for the other daughter. The dentist asked the patient if she wanted to consult with her mother, but she insisted that this was not necessary. After the teeth were removed, it was determined that the insurer would not cover the full cost of treatment. The patient's mother refused to pay for the procedure because she was not informed of the cost. Although the patient was old enough to consent to the treatment, her parents should have been informed as they were paying for the treatment. A review of the patient chart raised concerns about the dentist's recordkeeping and informed consent protocols, as no consent discussions were recorded and it was not possible to determine which dentist in the practice provided treatments. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 51	**Complaint** A patient complained that Dentist A used all of her insurance coverage attempting to restore two molars that she had asked him to remove. Dentist B, who now owned the practice, later told her the teeth needed to be extracted and she no longer had sufficient coverage to pay for it. **Investigation** Dentist A was aware of the patient's limited dental coverage and her wish to have both teeth extracted. He believed he could restore the teeth and the patient consented to the treatment when he promised her that the cost would be within the limitations of her coverage. After the restoration treatment, the patient returned for a follow-up appointment and learned that the dental office had been sold to Dentist B, who informed her that both teeth needed to be extracted. Dentist B was unaware of the fee arrangements proposed by Dentist A and gave the patient an estimate for the procedure.

	CDSBC Investigators questioned why Dentist A had started treatment that exhausted the patient's limited dental coverage, especially given the poor condition of her teeth. Dentist A had expected Dentist B to honour the agreement established with the patient without having discussed it with him. When Dentist B learned about the situation, she agreed to remove the teeth within the limits of the patient's plan. A review of the patient chart did not reference the patient's symptoms or testing done to confirm the diagnosis. There was also no reference to any informed consent or financial agreement. **Resolution** Dentist A signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses and undergo a chart review and monitoring.
File 52	**Complaint** A patient complained that her bridge failed and could not be replaced due to tooth decay caused by gaps under the bridge. **Investigation** The patient claimed the bridge felt loose when the dentist placed it, but the dentist assured her it was fine. When the patient returned with concerns that the bridge still felt loose, the dentist took X-rays and saw no evidence that anything was wrong. When the patient returned a second time, the dentist told her that the bridge was going to fail unless she had her bite restored to lessen stress on the bridge. The dentist knew about the gaps under the bridge and the patient's high rate of decay, but intended to proceed with the restoration of the patient's bite with a second bridge and address the gaps later. The dentist stated that the patient was not following the home hygiene recommendations that she was given, but the treatment plan did not address these issues. The dentist did not see the patient again before she sold her practice, and the gaps were never addressed. Another dentist later treated the patient and informed her that it was too late to restore the bridge and that she now required implant surgery. **Resolution** The dentist has since stopped practising dentistry, but if she wishes to return to practice, she will be required to sign an agreement to take

	CDSBC's *Dental Recordkeeping* course and join a study club on occlusion (bite) and the diagnosis and treatment of fixed prosthodontics.
File 53	**Complaint** A patient complained that the dentist damaged healthy enamel on the back of one of his teeth because she was distracted during treatment. **Investigation** The patient returned two days after the dentist placed a filling, reporting a rough spot on the back of the tooth. The dentist polished the area and recommended that the tooth be crowned, as it had previously had root canal treatment. At this point, the patient became agitated and was asked to leave the office when he started using profanity. The dentist did not understand the basis of the patient's concern because the tooth was not damaged and he was not in pain. The dentist denied being distracted during any of the treatment. A review of the patient chart confirmed that the treatment was appropriate, but lacked detail such as informed consent discussions and the patient's dental history. **Resolution** The dentist signed an agreement to take the CDSBC's *Dental Recordkeeping* course.
File 54	**Complaint** A patient complained that six crowns placed on her front teeth were the wrong size and colour, and were causing her jaw problems. The patient said that the dentist initially told her he would replace the crowns, but later refused to do so and dismissed her as a patient. **Investigation** During the consultation process, the patient did not allow the dentist to take X-rays or do other work-up procedures or models. The patient went against the dentist's recommendations and chose her own crowns, approving them before they were cemented. The patient returned for a number of bite adjustments, but remained unhappy with the crowns. The dentist offered to replace the crowns, as long as she paid her outstanding balance and was accompanied by another person during the treatment. The dentist did not hear from the patient for four years. When the patient returned to the office to have the crowns (one

	of which was now chipped) replaced, the dentist declined because so much time had passed and dismissed her as a patient. The investigation revealed concerns about the dentist's recordkeeping, treatment planning and informed consent protocols. The patient chart was inadequate, did not reference the patient's medical history, and did not document whether other treatment options were discussed. The dentist should not have allowed the patient to dictate the course of treatment and he should not have proceeded without the X-rays, models and other work-up records. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to join a prosthodontic study club (or take courses in complex restorative dentistry with a focus on prosthodontics).
File 55	**Complaint** A patient complained that she was asked to pay for the replacement of two crowns, even though they were covered by a five-year warranty. She also complained that the dentist changed the treatment without telling her and completed three root canal procedures instead of the two, as agreed. **Investigation** The dentist evaluated the patient and agreed that the two crowns (which had been placed by his former associate) had gaps that needed to be fixed. The dentist told the patient that she required two root canal treatments before she could proceed with the crowns. The dentist did three root canal procedures instead of two, but did not let the patient know beforehand and could not explain to CDSBC Investigators why the treatment plan changed. The patient chart did not record the reasons. The patient chart was generally comprehensive and supported the treatment, but there was no written treatment planning, and there were concerns with the dentist's root canal treatment diagnosis and informed consent protocols. The dentist said that he never intended to charge the patient for the new crowns. Not all of the office's interactions with the patient were recorded and since no cost estimates were provided to the patient, she was confused about the fees she was being charged. **Resolution**

	The dentist signed an agreement to take an endodontic diagnosis and treatment planning course, complete CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and undergo a chart review and monitoring.
File 56	**Complaint** A long-time patient complained that the dentist failed to diagnose his gum disease. **Investigation** The dentist said that he had spoken with the patient about some signs of gum disease, such as deep spaces around the teeth. He said that the gum disease was stable throughout his time treating the patient. The patient agreed that this had been discussed, but did not understand that he had an active disease. The patient chart revealed that the office's recordkeeping system was not adequate. The patient had only 13 hygiene appointments in 15 years. He had three teeth extracted – likely due to his gum disease – although this was not noted in the chart. The hygienist periodically examined his gums, but this was not recorded in the chart. The patient went to a new dentist about teeth that were loose and appeared to be infected. He learned that he had advanced gum disease with bone loss, gum recession and many loose teeth. He was at risk of losing a number of teeth. The patient was referred to a certified specialist and has since responded well to treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and be mentored by a periodontist, followed by a chart review and monitoring.
File 57	**Complaint** A patient complained that she experienced sensitivity and other problems after receiving fillings from the dentist. She also complained that two of the dentist's associates told her that the treatment was fine, but when she sought an opinion from another dentist, he recommended that two of the fillings be redone. **Investigation**

	The dentist had warned the patient that she might experience some temporary tooth sensitivity after treatment, especially in one tooth that required a deep filling. The patient returned the next day complaining of sensitivity, but declined a bite adjustment recommended by the dentist. Two of the dentist's associates advised the patient that sensitivity is not uncommon following treatment and the problem could resolve on its own. When the patient saw a new dentist three months later, he suggested removing the deep fillings to resolve the discomfort, but the patient did not proceed. When the patient filed the complaint, the sensitivity had resolved, but she still experienced pain when chewing on one side. CDSBC Investigators felt that the treatment was appropriate, but the patient chart should have included more detail regarding the diagnosis and other interactions with the patient. The dentist said that she had only been practising dentistry for about a year at the time of the complaint and she now takes more detailed notes. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course.
File 58	**Complaint** A patient complained that implant surgery by the dentist caused paresthesia (extended numbness and prickling/burning sensation) and chronic pain. She said that the dentist did not advise her of the risks and did not give her the option of having a CT scan done first. **Investigation** The dentist used a dental implant to better hold the patient's ill-fitting denture in place. He used a pre-treatment X-ray to ensure that the implant was properly placed, but did not take a CT scan. The day after treatment, the patient called the office to say that the freezing had not worn off. As there was no indication of nerve damage, the dentist believed that it would resolve over time. When the patient's symptoms worsened, a CT scan was taken which confirmed that the placement of the implant was causing nerve damage. The dentist consulted with two oral surgeons, and decided to remove the implant. However, when the patient's condition significantly improved, the dentist decided to leave the implant in and monitor the patient closely. The

	other dentists involved in her care agreed that the implant should not be removed as it might worsen her condition. The patient's chronic pain later returned and a neurologist prescribed her a drug to manage the nerve pain. The patient chart did not reference the discussions about informed consent and the risks associated with treatment that the dentist said he had with the patient. It was also missing other important information, such as the type and amount of anaesthetic administered. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. The College was satisfied that the dentist addressed the diagnostic concerns raised in the complaint by taking courses in implant diagnosis and treatment planning, and by joining an implant study club that includes treatment planning, case reviews and implant placement. He is now more conscious about when CT scans should be taken.
File 59	**Complaint** A patient complained that the dentist recommended unnecessary treatment after he obtained a second opinion that confirmed that his teeth were healthy. **Investigation** The dentist explained that the proposed treatment was preventive and entirely optional. The dentist said that he had told the patient that the treatment was not mandatory, but would reduce plaque and stain accumulation and prevent decay in difficult to clean areas. The front desk staff provided an incorrect treatment plan and fee estimate to the patient. When the patient expressed confusion, the dentist was not notified, as per the office's usual protocol. The dentist believed this was because the office was training new staff at the time. He agreed that this must have been confusing and frustrating for the patient. The patient chart confirmed the proposed treatment, but there was no indication that the treatment was optional, and no reference to the informed consent discussions the dentist said he had with the patient. **Resolution** The dentist signed an agreement to take three CDSBC courses: *Dental Recordkeeping, Tough Topics in Dentistry,* and *Avoiding Complaints*.

File 60	**Complaint** Dentist A complained about a letter she received from Dentist B criticizing the quality of care she provided to a patient, demanding she repay treatment costs to the patient, and threatening to report her to CDSBC if she did not comply. **Investigation** Dentist B said that the patient was very upset and that he was shocked by the work that had been done by Dentist A. Dentist B questioned Dentist A's treatment plan and felt that the patient's front teeth had been compromised by unnecessary root canal treatment. CDSBC Investigators asked Dentist B why he did not contact Dentist A directly with his concerns. He said that he wanted to ensure that the patient's costs were covered but did not feel that there was value in contacting Dentist A. He acknowledged that he could have been more tactful and agreed to contact a dentist directly if faced with a similar situation in the future. The patient chart did not include notations that the patient had been advised of all treatment options, which raised some concerns about Dentist B's recordkeeping. The records suggested that there was merit to Dentist B's concerns and a separate investigation was opened to look into Dentist A's treatment. **Resolution** Dentist B signed an agreement to contact any previous treating dentists if he has concerns regarding their treatment, to ensure that he has the necessary background to inform his treatment decisions. He also agreed to complete CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 61	**Complaint** A patient complained that the dentist failed to confirm treatment costs and that she was charged too much for the re-treatment of a root canal. The patient asked the dentist for an estimate, but was told not to worry because her dental plan would cover the cost. The patient compared the fee with other dental offices and found that her dentist was more expensive. **Investigation**

	The patient came to the dentist with pain in a tooth that had been previously root canal-treated. The dentist took X-rays and outlined treatment options with the patient (including a referral to a specialist, which the patient declined). The patient was given a written estimate and agreed to four root canals, with the understanding that if the dentist could not complete the procedure, she would have to see a specialist but would not be charged for the initial treatment. The treatment was completed over two appointments. The dentist's office did not receive the patient's insurance information until her last visit, at which time she objected to the cost. The insurance covered part of the cost, but the patient was responsible for the remaining balance. She did not pay the bill, so the dentist's office referred it to a collection agency. The dentist's records lacked detail and did not include the treatment estimate, the patient's medical history, or a final X-ray to assess the treatment results. The dentist said that the office's protocol was to delete treatment plans after treatment was completed, which is contrary to CDSBC's *Dental Recordkeeping Guidelines*. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. She also agreed to take a hands-on endodontic course followed by a chart review and monitoring.
File 62	**Complaint** A patient complained that the dentist did not explain the diagnosis or treatment plan before beginning treatment. **Investigation** At the new patient examination, the dentist noted a number of issues; these were discussed with the patient but the patient chose not to undergo all of the recommended treatment. The patient says that the dentist gave him a fee estimate but did not explain the procedure or answer the patient's question about why X-rays were needed. On his next visit, the patient was surprised to learn that the dentist was planning to contact his physician about discontinuing his heart medication so that he could undergo extensive dental treatment.

	CDSBC Investigators were concerned about the dentist's recordkeeping and informed consent protocols, as the patient chart suggested that the patient did not understand the nature of his dental condition. Conversations the dentist said she had with the patient were not recorded and there were no treatment notes. In addition, some of the issues noted by the hygienist were never discussed between the patient and the dentist. There were also concerns about the dentist's diagnosis and treatment planning, and X-ray interpretation, as the patient chart revealed that the dentist missed diagnosing a number of problems, including gaps, a lesion in the root of a tooth, and restoration issues on two teeth. **Resolution** The dentist signed an agreement to take courses in X-ray interpretation, diagnosis and treatment planning, take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and undergo a chart review and monitoring.
File 63	**Complaint** A patient with a broken tooth complained that the dentist extracted the wrong tooth. **Investigation** The dentist believed he was examining the tooth the patient was referring to, when in fact, he was not. The dentist's assistant had taken an X-ray of the wrong tooth and the dentist did not independently verify which tooth was bothering the patient. The dentist advised the patient that the tooth was restorable, but extracted it because the patient insisted. A week later the patient called to report that the wrong tooth had been extracted. He later returned to have the correct tooth extracted. A review of the patient chart raised concerns about the dentist's recordkeeping and informed consent protocols. Investigators were also concerned that the dentist prescribed antibiotics at the patient's insistence, even though he did not agree that the area was infected. The dentist should not have allowed the patient to dictate the course of treatment. **Resolution** The dentist signed an agreement to verify with patients which tooth is being treated, take CDSBC's *Dental Recordkeeping* and *Tough Topics in*

	Dentistry courses, and not to prescribe antibiotics unless there is a clinical reason to do so.
File 64	**Complaint** A patient complained that the dentist's delay in providing follow-up care after extracting a tooth caused her symptoms of swelling and infection to worsen. She may now develop facial scarring. **Investigation** When the dentist extracted the patient's tooth, a temporary crown (on the tooth next to it) came off. The dentist re-cemented the crown but advised the patient that the tooth was loose and she should consult with a periodontist. The patient said that when she called the dentist's office to report the swelling and infection symptoms, the receptionist assured her that what she was experiencing was normal and told her to apply a warm compress. The dentist saw the patient for follow up on five occasions: he irrigated and drained the area and prescribed antibiotics for the infection and recommended that the patient consult with her family doctor. He did not refer her to an oral surgeon because he felt that the follow-up he completed was appropriate. A review of the records support his response; however, there were concerns about his recordkeeping and X-ray interpretation. The records did not reference the phone calls the patient made to the office and there was no indication that the dentist attempted to source the origin of the infection. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and a course in X-ray interpretation, and to direct his staff to refer all questions about clinical advice to him.
File 65	**Complaint** An elderly patient complained that when she saw the dentist to ask if the implants that she had for more than 20 years could be used to support a new partial denture, the dentist began treatment without her consent and without providing a cost estimate. She also complained that staff advised her daughter of the treatment in a crowded waiting room, rather than in private. **Investigation**

	The patient said that the dentist exposed the implants without her consent and without explaining what he was doing. The dentist said that he did discuss the need to expose and assess the implants with the patient beforehand (and that the referring dentists had also discussed this with her) and gave her a verbal cost estimate; however, none of these discussions were recorded in the patient chart. The dentist was advised by CDSBC Investigators not to assume that the referring dentist gave the patient all of the required information, and that it is his responsibility to ensure that the patient understands the treatment options, risks and benefits, and costs. The dentist felt that it was common sense to report the details to the patient's daughter, but was advised by CDSBC Investigators that the patient must provide their consent to provide details of treatment with family members and that these conversations should occur in a private setting. Five days after the implants were installed, they felt loose and the patient returned to the dentist, as she thought there was an infection. The dentist prescribed antibiotics, despite indicating that there was no infection. CDSBC Investigators advised the dentist that this was not good practice. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, to ensure patient confidentiality, and to prescribe antibiotics appropriately.
File 66	**Complaint** An elderly patient complained of problems with two implants placed by the dentist: one failed immediately, while the other could not be restored because it was placed at an angle. **Investigation** The patient wanted to have implants, even though the dentist cautioned him that the outcome was not guaranteed given his age and complex medical and dental history. The dentist agreed to place the implants based on the patient's assurance that his diabetes and smoking were being properly managed to minimize risk. The first implant failed almost immediately and was removed by an oral surgeon at the dentist's expense. The second implant was slow to heal, but was ultimately successful. The dentist explained it was intentionally placed

	at an angle for bite purposes and he planned to restore the tooth later, but the patient declined additional treatment. (A different dentist later recommended removing the implant rather than attempting to restore it.) The investigation raised concerns about the dentist's decisions to proceed with treatment given that the implants would likely fail and the placement of the second tooth. It appears that the dentist allowed the patient to dictate the treatment and then blamed the patient's health issues for the failure of the procedure. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, a hands-on course on dental implants and undergo chart reviews during a monitoring period.
File 67	**Complaint** A patient complained about the quality of a bridge provided by the dentist, which was replaced twice by the dentist and again by a specialist. **Investigation** The patient saw the dentist to have a loose lower bridge re-cemented. The dentist was not able to remove the bridge intact, so a new bridge was placed at no cost to the patient. The patient complained that the new bridge did not fit properly and the porcelain chipped. The dentist thought the problems with the patient's new bridge were due to her heavy bite, but this was not noted in the chart and the patient said it was not discussed with her. After several bite adjustments did not resolve the issues, he offered to replace the bridge at no charge, but the patient didn't return to have this done until three years later. The dentist asked her to pay for the lab fees, and though she agreed, she was not advised of the cost until the new bridge was delivered. No X-rays were taken to assess the bridge before determining to replace it (which should have been done, given the time that had passed since the patient was last seen). The patient's problems did not resolve with the new bridge, so she saw a specialist who gave her an $8,000 estimate to replace the bridge a third time. CDSBC Investigators identified concerns with the dentist's recordkeeping and informed consent protocols.

	Resolution The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses. He also agreed to take a course on how to avoid restorative failure.
File 68	**Complaint** A patient complained that the dentist did not inform her that he had inserted a cotton pellet to bleach a tooth that had turned black, and that this led to eventually losing the tooth. **Investigation** The patient's tooth had turned black after a routine orthodontic appointment when she was a teenager. The dentist performed root canal treatment at no cost and at the end of the procedure inserted a cotton pellet containing hydrogen peroxide into the tooth to lighten its colour. The dentist replaced the pellet five months later to continue the bleaching process, and again almost two years later when removing the patient's braces. The dentist said that the patient and her mother agreed to bleach the tooth and that he had outlined treatment options with the patient's mother when she called to say that the bleaching was not working. The mother reportedly said that she would discuss the options with her daughter and get back to the dentist, but she did not do so. CDSBC Investigators found that the dental office did not follow-up with the patient or her mother. As a result, the pellet was not properly refreshed, which led to decay and loss of the tooth a few years later. CDSBC Investigators found that the dentist's records were inadequate and did not mention informed consent discussions. There was no evidence that the patient was aware that the dentist had done the internal bleaching procedure, nor of the associated risks. While it was found to be an isolated incident, there was also a slight concern about the quality of the dentist's root canal treatment. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, to develop a protocol to follow up with patients, and to consider taking an endodontic refresher course.

File 69	**Complaint** The parent of a young patient complained that the dentist did not advise him about the details or the cost of his daughter's treatment until after it was complete. He was charged $1,300 more than an estimate given from another dentist in the same office. **Investigation** The dentist was unaware of the estimate provided to the patient's father by his associate dentist. He told the parents that he would only be able to fully assess the patient's dental needs once she was under anaesthetic and X-rays could be taken. The patient required extensive restorations due to "baby bottle tooth decay." The dentist said he discussed this with the parents; however, the father claimed that he only became aware of his daughter's treatment when he received the bill. A review of the records showed insufficient detail to confirm that any informed consent discussions had occurred. The investigation revealed concerns about the dentist's recordkeeping and informed consent protocols. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 70	**Complaint** The parent of a two-year-old patient complained that the dentist provided him with an estimate for his daughter's treatment and then charged him almost double the amount. **Investigation** The dentist based the estimate on a limited clinical examination, and advised the parent that additional treatment would likely be needed and would be confirmed once the procedure was underway. The parent had agreed to proceed with the treatment, but asked to be notified if the cost exceeded his budget. The dentist failed to communicate the budget concern to his associate who performed the treatment, and did not notify the parent when the cost increased. The dentist acknowledged that his patient charting was minimal and a review revealed that it did not reference any diagnostic findings nor any

	informed consent discussions with the parent. He said that he usually includes this information and communicates with his colleague about patient care, but that did not occur in this case. **Resolution** The dentist addressed the parent's concerns by offering a 15% discount and an installment payment plan. He signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 71 & 72	**Complaint** A dental hygienist complained about the dentist and a certified dental assistant (CDA). The hygienist complained that the dentist did not properly supervise staff and delegated duties to his CDA that are not part of the services a CDA is permitted to provide, including administering B12 injections and Botox®, and participating in discussions with patients involving X-ray interpretation. **Investigation** The hygienist tried to set up a meeting to discuss her concerns with the dentist, but the CDA, who was also the office manager, would not allow it. The hygienist claimed that her employment was terminated as a result of this situation. The dentist denied that the CDA performed duties that she was unqualified or unauthorized to do, with an exception being that she administered a Vitamin B12 injection to a staff member. The CDA admitted that she gave the injection, but otherwise denied that she performed any restricted activities. The dentist said that there had been a personal dispute between the hygienist and the CDA. When he started his own practice, both joined him in the new office after assuring him that they could continue to work together. Tensions grew when he promoted the CDA and left the day-to-day management of the practice to her. The dentist confirmed that, as office manager, the CDA was in charge of overseeing the dental team, including hiring and firing of staff, and had some involvement in new patient examinations and discussions. The CDA said that she does not interpret patient X-rays. A number of staff members provided statements that supported the dentist's claim and there was no evidence found to suggest that the CDA

	was performing duties that a CDA is not permitted to perform. However, the investigation revealed a number of concerns about the dentist's lack of involvement in the management, billing, and financial aspects of the practice. **Resolution** The dentist signed an agreement to be more involved in supervising staff and overseeing financial transactions at his practice. He also agreed to immediately stop offering B12 injections to staff. The CDA signed an agreement to immediately cease administering Vitamin B12 injections and to only perform duties set out in CDSBC's *A Guide to CDA Services.*
File 73	**Complaint** A patient complained that a tooth treated by the specialist (endodontist), fractured and needed to be extracted only seven months later. **Investigation** The patient was referred to the specialist who explained that the prognosis for the tooth was uncertain because it had been root canal-treated 20 years earlier. The referring dentist had planned to crown the tooth after it was treated, but the specialist strongly recommended that this not be done until he could ensure that all issues were resolved after surgery. The specialist did not discuss the option of extracting the tooth because he had successfully treated similar cases in the past and believed he could save the tooth. Following the surgery, the specialist advised the patient's husband of the poor prognosis of the tooth and gave him post-op instructions. However, this discussion was not recorded in the chart. The specialist sent a follow up report to the referring dentist confirming his diagnosis, but the patient had switched to a new dentist and so did not receive the note. The patient knew of the specialist's recommendation not to crown the tooth, but believed this was because no further treatment was needed and she did not know that there was a poor prognosis for her tooth. The investigation did not raise a concern about the standard of care, but did suggest the specialist's recordkeeping and informed consent protocols needed improvement.

	Resolution The specialist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 74	**Complaint** A patient complained that the dentist did not advise her of complications that occurred during root canal treatment, and that he later did not provide her with her complete records, despite numerous requests. **Investigation** The dentist said that the root canal treatment was a complex case. The appointment was scheduled for 45 minutes but took two hours. During the procedure a file tip separated and was left in the tooth. After the treatment, the dentist advised the patient of the separated file tip and recorded it in the patient's chart. He also called her regular dentist the next day to let him know. It appears that the treating dentist did not clearly explain the complications to the patient because she did not realize what had happened until she saw her regular dentist. After speaking to her regular dentist, the patient contacted the treating dentist for an explanation and to request her chart. The dentist didn't think he could give records directly to the patient and sent them to her regular dentist instead, causing a delay. A review of the dentist's records found that there was a significant overfill in one of the canals and that he had not referred the patient to a specialist to see if the file tip could be removed. **Resolution** The dentist was advised that patients are entitled to a copy of their records. He signed an agreement to review CDSBC's *Dental Recordkeeping Guidelines,* take an endodontic course or join an endodontic study club, take CDSBC's *Tough Topics in Dentistry* course, and undergo a chart review and monitoring.
File 75	**Complaint** A patient complained that four crowns placed by the dentist were the wrong colour and affected his bite because they were too big. The patient said that the dentist never discussed the risks or potential complications of the procedure before starting treatment.

	Investigation The long-time patient asked about improving the look of his teeth. Four teeth at the front of the patient's mouth were crowned. The X-rays confirmed a good result was achieved, although the patient was concerned about the size of the crowns, which were affecting his bite. The dentist admitted that his informed consent protocol needed improvement, as he did not discuss the risks and benefits of the treatment with the patient beforehand. He also acknowledged that his records did not meet standards and did not include treatment details or mention other treatment options discussed. The dentist advised that he had already improved his recordkeeping by taking CDSBC's *Dental Recordkeeping* course. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* course.
File 76	**Complaint** The parents of a 5-year-old patient complained about the treatment provided by the dentist. They said that he did not take X-rays of their son's teeth and that some of the teeth he restored needed to be re-treated. Another dentist who later treated the patient found that eight teeth had cavities (five of which required crowns). **Investigation** The dentist explained that while he recommended taking X-rays to help his diagnosis, the patient's parents would not allow it. They also did not allow the dentist to complete a clinical examination. The dentist said he attempted to educate the parents about home care for their son but notes they did not appear to follow through on his recommendations and did not bring their son in for hygiene appointments. The dentist reported that the restorations done to the patient's teeth were difficult to perform because the child moved around a lot in the dental chair. It concerned CDSBC Investigators that the dentist had not referred the patient to a pediatric specialist during the year he was a patient, given that the parents were refusing treatment and the difficulty completing the restorations.

	While the complaint did not raise concerns about the dentist's operative competency, there were other problems. The patient chart did not reference any informed consent discussions with the parents or note the fact that they had refused X-rays and hygiene visits. CDSBC Investigators advised that any refusal of treatment should be clearly documented in the chart. **Resolution** The dentist signed an agreement to take the CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, to develop a form for patients to sign when they decline X-rays, referrals or the dentist's treatment recommendations, and to undergo monitoring.
File 77	**Complaint** Two principal dentists at a dental clinic complained that an associate dentist took confidential patient contact information from the clinic. **Investigation** Staff witnessed the dentist print out the contact information for all 1,700 patients at the clinic. The dentist initially denied taking the information, but then handed the printout over to the office manager. He left with a USB drive that the principal dentists suspected also had patient information on it. The dentist confirmed that he had printed patient contact information, but claimed his intent was to make notations about the status of their treatment, as he was planning to resign the following week. He said that he wanted to make notes in the charts to assist the new associate dentists and ensure continuity of patient care. He denied that the USB drive contained anything but his own personal information. He acknowledged that he had signed an associate agreement that prevented him from removing any information relating to patients from the practice without the consent of the principal dentists, which he did not have. His employment was terminated as a result of this incident. The dentist did not acknowledge that his conduct was unethical and potentially compromised patient confidentiality, in addition to a breach of his associate contract. **Resolution** The dentist signed an agreement to pay a $5,000 fine and take an ethics course. A monitoring file was opened to track the dentist's compliance.

File 78	**Complaint** A patient complained that the dentist could not resolve fit issues with the dentures he provided, was not wearing gloves when he placed the dentures, and that he had humiliated him by delivering the dentures in a public area. **Investigation** The dentist acknowledged that the upper dentures were loose when the patient first tried them on, but proceeded to deliver them to the patient anyway. He was unable to resolve the fit issues by making adjustments. The patient said that another dentist later advised him that the dentures had to be remade, which he could not afford. The patient later confirmed that he received a full refund from the dentist. The dentist delivered the dentures outside of his office because it was not wheelchair accessible, which he said he had advised the patient of beforehand. A review of the records revealed unsigned consent forms and a lack of detail about his interaction with the patient. No reference was made to the medications the patient was taking to manage his disability and the chart simply stated that the patient was in a wheelchair. **Resolution** The dentist has since stopped practising dentistry, but if he wishes to return to practice, he will be required to sign an agreement to complete a remedial program to address the concerns about his diagnosis and treatment planning, recordkeeping, and informed consent protocols.
File 79 Also see related: File 108	**Complaint** A patient complained about the bill she received for treatment provided by the dentist, saying that she was not provided with a detailed treatment plan and cost breakdown before treatment, despite many requests. **Investigation** The patient came to the dentist to have a tooth extracted, and an implant and a crown placed. A comprehensive treatment plan was discussed and a fee range was given to the patient at the consultation. The patient was promised an estimate but it was never provided, despite many requests and email exchanges with the office manager. The patient thought that the costs would be lower as she chose not to be sedated during surgery and believed

	that no bone grafting was done (records confirm a bone grafting procedure was done). While the patient was satisfied with the treatment outcome, she was concerned about staff not giving her written confirmation of her treatment plan or cost estimate before being billed $14,000. The dentist had relied on his office manager to provide the patient with the documentation she required. He later learned that the office manager was embezzling significant sums of money from him during this time. The dentist has since sold his practice and the office manager is now the subject of criminal proceedings. The dentist said that he has adopted the informed consent protocols of the principal dentist he currently works with and now provides patients with a much more detailed written treatment plan. **Resolution** The dentist signed an agreement to ensure that all patients are provided with detailed written treatment plans, along with a financial breakdown of each procedure prior to initiating treatment, and acknowledged that it is his responsibility to oversee his staff and ensure that their interactions with patients are professional and timely.
File 80	**Complaint** A patient complained about the fit of the dentures provided by the dentist. **Investigation** The patient's teeth were extracted so he would be ready to receive dentures. He was told to return to have impressions taken for his dentures after a six to eight week healing period. During that time, the dentist left the office and a number of dental associates took over the patient's care. There was no concern with the actual dental work done by the dentist; however, the records did not show evidence of informed consent discussions with the patient regarding treatment options. The dentist explained that charts were completed by certified dental assistants at that dental office and that associate dentists were not involved in charting. The dentist was advised that it is the responsibility of the treating dentist to oversee chart entries and ensure that they are complete and accurate.

	As the dentist was no longer involved in the patient's care when the dentures were made, CDSBC Investigators could not address the complaint as it related to their fit. **Resolution** The dentist signed an agreement to review the *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 81	**Complaint** A patient complained about the fit of lower dentures made by the dentist. **Investigation** The dentist became involved in the patient's care after an associate dentist extracted his remaining teeth in preparation for dentures. The dentist took several impressions and once he and the patient were both satisfied with the fit, aesthetics and function of the impressions they were sent to the lab to be made. The dentist advised the patient that it would take some time for him to adjust to the new dentures. The patient returned for minor adjustments, but was not seen again for a year. When he returned, the patient told the dentist that the lower denture was still uncomfortable and could not be used to chew food. The dentist outlined a number of treatment options to improve its hold, including implants or having a denturist make adjustments. She referred the patient to a denturist and an implant specialist and did not see the patient again. The patient was later seen by another dentist and reported that the dentures now fit comfortably and he can use them to chew food. The investigation did not find any problems with the treatment undertaken by the dentist; however, the chart revealed recordkeeping concerns (no reference to whether treatment options were discussed with the patient, some of the entries were not initialed or dated, making it difficult to confirm who provided the treatment). **Resolution** The dentist signed an agreement to review the *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 82	**Complaint**

	The person paying for treatment complained on behalf of a patient that the final bill was 20% more than the estimate provided. **Investigation** During the patient's initial consultation, the dentist developed a treatment plan and gave a cost estimate to the patient. The dentist said that he advised the patient that the cost might change depending on what happened during the surgery, but the patient does not remember this. The treatment plan and cost estimate were not confirmed in writing. The dentist now does this routinely since he sold his practice and has adopted the informed consent protocols of the principal dentist. The complainant wrote a letter to the dentist, but because he was not the person receiving treatment, the dentist did not respond. The dentist contacted the patient to advise her that he would need her consent to discuss her treatment costs with the complainant, but he never received her permission to do so. **Resolution** The dentist signed an agreement to provide all patients with more complex care needs with detailed written treatment plans along with a cost breakdown of each procedure prior to initiating treatment.
File 83	**Complaint** The mother of a patient complained about the outcome of orthodontic treatment that her daughter received from the orthodontist, including bite issues and aesthetic concerns. **Investigation** Before undertaking treatment, the orthodontist monitored the patient's teeth for two years. After the orthodontic treatment, the patient was instructed to return in four months so he could check on the retainer, but the patient only returned 10 months later. At this appointment, the patient told the orthodontist about concerns with her bite. He made some adjustments with the hope that he could correct the bite, but it appears that the patient was unaware of this course of action and did not return for the recommended follow-up appointment. The patient returned to their family dentist, who referred them to another orthodontist when they expressed their discontent. The new orthodontist reviewed the records and recommended further treatment. The patient

	reported that one month into the re-treatment her jaw joint issues were resolved. The records provided by the original orthodontist revealed informed consent concerns: he did not discuss all of the treatment options with the patient, including the benefits, risks and costs. The original orthodontist said that he would have re-treated the patient had the family contacted him. If he had communicated the outcome and options for re-treatment with the family, they might have avoided the additional costs of re-treatment by a second orthodontist. **Resolution** The dentist signed an agreement to take CDSBC's *Tough Topics in Dentistry* course, to discuss all treatment options (and risks and benefits) with his patients, and to record these discussions in the chart, and to include alternative treatments and options available when a poor result occurs at the end of treatment.
File 84	**Complaint** A patient complained about the dentist's response to her concern that her bridge was bulky and uncomfortable. The patient complained that the dentist told her there was nothing wrong with the treatment and that she felt ambushed when he dismissed her as a patient. She also claimed that the dentist was unprofessional and would slap her hand away during treatment. **Investigation** The dentist outlined treatment options to address the patient's poor bite and she chose to have two lower bridges followed by a partial upper denture. The dentist said he worked with the patient to ensure that she was satisfied with the fit before placing the bridges. He made several adjustments in an attempt to address the patient's concerns, and tried to explain why the adjustments would take time. The dentist said that the patient had a habit of moving her hands to her mouth during treatment. He said he considered this unsafe, and so would firmly place the patient's hands in her lap when she did this, but denied that he ever slapped them away. The dentist arranged a consultation with the patient to address her concerns by referring to the models taken, but the patient appeared to be fixated on the size of the teeth and was not listening to him. The dentist dismissed the patient and offered to send the patient's denture to another

	dentist at no cost so she could obtain treatment from someone she felt more comfortable with. The dentist was advised that he should have referred the patient to a specialist (prosthodontist) sooner, when it first became clear that her expectations were not being met. The patient chart revealed that the dentist did not confirm the dosage of Ativan taken by the patient prior to appointments, and that the patient was taking the Ativan at home before driving herself to and from each appointment. Given the patient's age and that Ativan is a sedative, the patient should not have been driving. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and review the *Minimal/Moderate Sedation Standards & Guidelines.* The dentist agreed to consider taking occlusion courses as part of his Continuing Education requirements.
File 85	**Complaint** A patient complained that an implant placed by the dentist failed and required further treatment. **Investigation** The patient already had a number of implants when he met with the dentist about an implant to be placed in a molar site. The dentist advised the patient that he had enough bone to support a short implant and that a bone grafting procedure would not be necessary. The implant was placed and a follow up appointment showed that the implant was healing well and appeared to be fully integrated. The patient received a second opinion from a dentist who told him that he would need a bone scan and a sinus lift to ensure that the implant would stay in place for the long term. On the basis of this information, the patient told the treating dentist that the implant had failed and that he wanted a refund. The dentist refused to issue a refund because there was nothing to suggest that the implant had failed or was likely to fail. The records provided by the second dentist confirmed that the implant had healed well, and he said that he only suggested a sinus lift when the patient asked him what he would do if the implant were to be redone.

	The patient chart supported the treatment but raised recordkeeping concerns: chart notations were not in chronological order, and there was no reference to treatment planning nor the informed consent discussions the dentist said he had with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course, followed by a chart review to further assess his recordkeeping protocols.
File 86	**Complaint** A patient complained that the crowns that the dentist placed following two implants had loosened numerous times, which made him question whether the dentist was qualified to handle implant procedures. **Investigation** The dentist separately placed two implants for the patient. The crowns on both implants failed shortly after they were placed, so the dentist re-cemented them and made minor adjustments. The dentist left the practice soon thereafter, and presumed the patient's concerns had been successfully addressed since he had not heard from him again. The dentist only became aware of the patient's ongoing problems when he received the complaint. He explained that the implant system he used was approved at the time, but that due to problems holding the crown in place, he no longer uses this system for certain teeth. He indicated that he has taken continuing education related to implants, but they all appeared to be within this particular implant system. A minor recordkeeping concern was noted when the charts were found to be somewhat lacking in detail. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and acknowledged that if he continues to offer implant treatment as part of his practice, he should take a hands-on implant course or join a study club to broaden his experience with other implant systems.
File 87 Also see related: File 141 & File 142	**Complaint** A patient complained about a partial denture delivered by the dentist, and also questioned her diagnosis that his teenage daughter had three cavities, after another dentist advised that there was no evidence of decay on her teeth.

	Investigation The dentist stated that the patient was satisfied with fit of the denture when it was delivered. He did not return with any complaint, so the dentist was not able to address his concerns. The patient admitted that he did not see the dentist about his concerns with the denture, and that he was still wearing it and has not had it adjusted by another dentist. Regarding the daughter's diagnosis, the dentist provided X-rays that clearly showed evidence of decay on three of her teeth. During his daughter's appointment, the patient attempted to have the office refund the deposit he had paid for his denture and claim it through his daughter's dental plan. When the dentist refused and explained that this was illegal, the patient was very upset and removed his daughter from the dental chair before her treatment was complete. The patient's daughter then saw a new dentist who signed a letter written by the patient confirming that there was no obvious evidence of decay. However, three CDSBC Investigators reviewed the X-rays and found clear evidence of decay, supporting the diagnosis made by the original treating dentist. Note: there is a separate complaint (File 141) that addresses the conflicting reports of the diagnosis by the second dentist. The investigation brought to light concerns with the original dentist's recordkeeping, which lacked some information about patient medical history and medications. **Resolution** The dentist signed an agreement to review the *Dental Recordkeeping Guidelines* and take CDSBC's *Dental Recordkeeping* course, and acknowledged the importance of carefully reviewing a patient's medical history and medications because it may impact the recommended treatment.
File 88	**Complaint** An investigation was opened when, during the course of a separate investigation, CDSBC learned that the dentist may have been administering moderate sedation without CDSBC approval and that an anesthetist may have been providing deep sedation without a facility inspection. **Investigation** When questioned by CDSBC Investigators, the dentist confirmed that he brought in anaesthesiologists to administer moderate sedation. He was

	assured that the anaesthesiologists were qualified and acted in accordance with the sedation guidelines at all times. The dentist has since sold his practice and is no longer practising dentistry. He acknowledged that his recordkeeping protocols with respect to sedation could have been improved and said that he would update them should he return to practice. **Resolution** The dentist signed an agreement that requires him to take CDSBC's *Dental Recordkeeping* course and provide the College with evidence that he is complying with the sedation guidelines if he applies for reinstatement.
File 89	**Complaint** A patient complained that she was in pain after the dentist placed veneers on her teeth, and that the dentist could not resolve the discomfort, despite treating all of the crowned teeth with root canal treatment. **Investigation** The dentist placed six veneers on the patient's front upper and lower teeth to improve their aesthetics. The patient was initially pleased with the results. She later returned complaining of pain. It became apparent that root canal treatment was necessary. The dentist filled the root canals using a less common material that made it difficult to determine whether the canals had been properly filled. The dentist told CDSBC Investigators that he used a special tool to check that the canals were properly filled. The patient remained in pain for five months until she saw a root canal treatment specialist who resolved her pain by re-treating all six teeth with conventional material. A review of the records revealed concerns about the dentist's recordkeeping, endodontic diagnosis and treatment planning. **Resolution** The dentist signed an agreement not to provide endodontic treatment until he has successfully completed a hands-on endodontic course, to take CDSBC's *Dental Recordkeeping* course, and to undergo a chart review and monitoring.
File 90	**Complaint**

	A patient complained that she underwent an extensive treatment plan to restore her teeth because the dentist assured her he could save them, but that the restorations failed in under two years and she was forced to have her teeth extracted and dentures put in. **Investigation** The dentist said that he discussed the various treatment options with the patient but never promised to "save" the teeth. The dentist said that the restorations failed because the patient did not follow proper oral hygiene between visits. The patient was a heavy smoker and was taking numerous medications for health issues, which caused dry mouth which contributed to the decay and deterioration of her teeth. The patient did not have a clear understanding of the treatment plan and because it was not confirmed in writing, she did not realize the consequences of not following the home care instructions she was given. A review of the records support the treatment provided. There were no concerns about the standard of care provided; however, the patient chart lacked detail regarding the informed consent discussions the dentist said he had with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses and to undergo a chart review.
File 91	**Complaint** A community advocacy group complained on behalf of a patient who does not speak English. The patient said that he suffered from a long-term infection after having a tooth extracted by the dentist and thought his tooth was growing back. **Investigation** The patient saw the dentist for an emergency situation. The tooth was extracted without any problems and the dentist did not see the patient again. When the patient went to see another dentist, it was determined that a root tip was left behind. The investigation clarified that the root tips were from another tooth, not the one extracted by the dentist. There was no evidence that the patient's infection was related to the tooth extracted by the dentist; however, CDSBC investigators were concerned about the lack of detail in the dentist's chart and the fact that no pre-treatment X-rays had been taken.

	Resolution The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course.
File 92	**Complaint** A patient complained that she felt uncomfortable during treatment because the dentist and his assistant were not behaving professionally, and that the bill to remove her wisdom teeth was higher than the estimate. **Investigation** The dentist confirmed that he diagnosed and extracted the patient's wisdom teeth. A review of the patient chart revealed concerns about the dentist's recordkeeping. The records did not include informed consent discussions and there was some concern that the dentist proceeded with a complicated surgery without advising the patient of the associated risks. The dentist admitted that he did not work well with his assistant that day because he felt that she should not be assisting in the surgery. The dentist was reminded that it is important to create a comfortable environment for his patients. The patient later confirmed that the principal dentist at the practice agreed to honour the initial estimate and this satisfied the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 93	**Complaint** A patient complained about the outcome of the orthodontic treatment she received from the dentist, saying that it altered her bite, creating contact between her upper and lower teeth that was painful and made it difficult to eat, speak, and sleep. The patient felt that the dentist failed to address her concerns before he dismissed her as a patient. **Investigation** The patient underwent 16 months of treatment to close spaces between her upper side teeth. The dentist said that she had lengthy consultations with the patient before and during the treatment to explain the approach and address her concerns. The dentist believed that the outcome was not achieved because the patient was attempting to dictate the course of treatment, which caused the dentist to dismiss her as a patient before the treatment was completed.

	A review of the patient chart raised concerns about the dentist's recordkeeping and informed consent protocols, as well as orthodontic diagnosis and treatment planning. It appeared that the dentist did not anticipate the type of complications that arose during treatment and did not discuss the risks with the patient prior to treatment. The patient did sign a consent form; however, it was generic and did not contain any details about the treatment plan or its risks and benefits. There was no indication that any other options were discussed with the patient. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to be mentored in orthodontic diagnosis and treatment planning protocols. A monitoring file was opened to track the dentist's compliance.
File 94	**Complaint** A new patient questioned the dentist's diagnosis and treatment plan, which suggested that seven teeth needed to be restored. The patient sought a second opinion from another dentist who advised that only one tooth needed treatment. **Investigation** X-rays were taken at the new patient exam and early decay was detected on several teeth. The dentist explained the rationale for the recommended treatment and felt that the patient understood the diagnosis and consented to treatment. A review of the patient chart raised concerns about the dentist's X-ray interpretation, diagnosis and treatment planning and decay management. CDSBC Investigators identified evidence of early decay on one tooth when they reviewed the X-ray, but did not see cause for concern on any of the other teeth. The dentist should have monitored the other teeth for several months after restoring the one tooth that required treatment. **Resolution** The dentist signed an agreement to take courses in X-ray interpretation and decay diagnosis, treatment planning and management, followed by a chart review and monitoring.
File 95	This file required public notification. Read the publication notice: Hardeep Birdi >>

File 96	**Complaint** A patient complained that her bridge came loose after the dentist treated one of the teeth that supported it with a root canal. **Investigation** The dentist said that the bridge was already loose due to the patient's periodontal issues and receding gums, and this was confirmed by a different dentist who later treated the patient. The dentist recommended root canal treatment to deal with a chronic infection on the tooth. She explained to the patient the potential risks of the treatment that involved making a hole in the top of the bridge to access the tooth. The X-rays showed that a good result was achieved, and did not show evidence that the bridge had been damaged by the root canal treatment. A review of the patient chart raised concerns with the dentist's informed consent and recordkeeping protocols. For example, the patient's medical history was incomplete, her medications were not listed, and the chart did not contain enough detail of informed consent discussions. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 97	**Complaint** CDSBC opened an investigation into concerns about the treatment provided by the dentist, which were noted during a separate complaint investigation. **Investigation** CDSBC Investigators were concerned about a failed prosthodontic treatment that the dentist provided to the patient. The dentist said that the patient insisted on this particular treatment against his recommendation. The dentist should not have allowed the patient to dictate the treatment given the significant risks and likelihood of failure. The structural integrity of some teeth was compromised as a result of the treatment, which led to issues with the prosthetics staying in place.

	Concerns with the dentist's diagnosis and treatment planning (for prosthodontics) were noted. The patient chart lacked detail about the treatment and informed consent discussions. **Resolution** The dentist signed an agreement to join a prosthodontic study club, take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to undergo a chart review and monitoring.
File 98	**Complaint** A patient suffered paresthesia (extended numbness and prickling/burning sensation) in her chin and lip after a tooth was extracted. **Investigation** Removing the tooth was complicated and required that it be sectioned. Root fragments also had to be removed. Because of this, the patient suffered some trauma to the nerve. The pre-treatment X-ray did not show that the patient had an unusual anatomy. It would not have been possible for the dentist to predict what problems may have arisen during the procedure. The patient chart confirmed that the patient was monitored for several months after the tooth was extracted. During follow-up visits, the patient reported an initial return of sensation. The dentist believed that the condition would resolve in time; however, three years later the patient still has paresthesia. The patient chart supported the rationale for the treatment and confirmed that the patient was informed of risks related to implant placement, but it is unclear if she was advised that paresthesia is a risk when teeth are extracted. The chart generally lacked detail and did not meet CDSBC's recordkeeping standards. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 99	**Complaint** A patient complained that when he returned to the dentist in pain after a filling, he was referred to another dentist for root canal treatment and was not given his dental records as requested.

	Investigation The dentist placed the patient's filling. When the patient returned in pain, the dentist told him that there was nothing wrong with it and gave him a referral to have the tooth root canal-treated (because he no longer did that type of treatment). The patient said he could not afford the proposed treatment and asked for his patient chart, which the dentist did not provide. The dentist said he was not aware that patients are entitled to their records, but knew that his receptionist gave the patient some records without his knowledge. The patient records were incomplete: there was insufficient charting, incomplete patient information, no health history, and nothing to confirm his diagnosis and treatment planning or informed consent discussions with the patient. **Resolution** The dentist is now retired, but if he wishes to return to practice, he will be required to sign an agreement to complete a remedial program to improve his diagnosis and treatment planning, recordkeeping, and informed consent protocols.
File 100	**Complaint** A patient complained that numerous crowns provided by the dentist needed to be redone, and in two cases the teeth had to be extracted. **Investigation** The patient came to the dentist with many broken teeth. The dentist believed that the patient's teeth were weakened from several years of chemotherapy and radiation treatment. The dentist root canal-treated and crowned many of the teeth. He thought that some of the crowns failed because of the patient's grinding habit and inconsistent use of her night guard. A review of the patient chart raised concerns about the dentist's informed consent protocols, and his endodontic and prosthodontic competency. **Resolution** The dentist signed an agreement to stop providing root canal treatment until he completes an endodontic course, take a course in restorations and CDSBC's *Tough Topics in Dentistry* course, and to undergo a chart review and monitoring.

File 101	**Complaint** A patient complained that two fillings done by the dentist failed and had to be redone by another dentist. **Investigation** The dentist said that the patient had struggled to keep his mouth open during treatment, which made it difficult; however, he took responsibility for the shortcomings of the work done and issued a refund to the patient, along with an apology that included an extra $1,000. The dentist acknowledged that he should have checked in with the patient during the procedure and followed up afterwards to check on the outcome. **Resolution** The dentist signed an agreement to take a restorative dentistry course and to undergo monitoring and a chart review.
File 102	**Complaint** A patient complained that three out of four crowns provided by the dentist failed within two years. **Investigation** Four teeth were crowned, one of which was root canal-treated afterwards. When three of the crowns failed, the dentist felt that it was because of the patient's clenching and grinding habits, inconsistent use of her night guard (although the patient said that she wore her night guard regularly) and the fact that root canal treatment was done through the crown. He agreed to repair or replace the failed crowns at a reduced rate. After the patient went to see another dentist, the treating dentist agreed to further reduce the price, but the patient refused further treatment from him and had all three crowns replaced by a new dentist. The patient chart supported the treatment rationale, but CDSBC Investigators were concerned about the dentist's informed consent protocols, as it did not appear that the full range of options was offered to the patient. The X-rays showed concerns with the root canal treatment on one tooth, and one poor-fitting crown. **Resolution**

	The dentist signed an agreement not to provide root canal treatment until he completed an endodontics course. The dentist also agreed to take a course in restorations and CDSBC's *Tough Topics in Dentistry* course, and undergo a chart review and monitoring.
File 103	**Complaint** A mother complained that the dentist did not advise her to take her son to the hospital for a chest X-ray to confirm whether he had inhaled a tooth. **Investigation** The tooth went missing after the dentist extracted it. The patient was coughing, but did not exhibit any breathing difficulties. The dentist said that the coughing seemed to be getting better, so he discharged the patient into his mother's care and told her to take the patient to the hospital if he had trouble breathing. The patient had inhaled the extracted tooth and had emergency surgery the next day to have it removed from his lung. The patient's mother contacted the dental office to advise them of the outcome because the dentist had not followed up. CDSBC Investigators were concerned about the dentist's handling of the emergency. **Resolution** The dentist signed an agreement acknowledging his responsibility to proactively respond to emergencies. He was also required to take a course on responding to medical emergencies in the dental office.
File 104	**This complaint was addressed as a health file.**
File 105	**Complaint** CDSBC opened an investigation after the dentist failed to respond to communications from CDSBC's Registrar. **Investigation** CDSBC contacted the dentist with concerns regarding his promotional activities about Botox® and dermal fillers. The dentist did adjust his website to address the concerns but challenged CDSBC's position that the administration of dermal fillers is outside the scope of practice of general dentists. The dentist refused to comply with the advertising and promotional activities guidelines and felt that CDSBC was singling him out. Because of his

	refusal, the dentist was asked to meet with a panel of the Inquiry Committee. The panel explained to the dentist that the Board has authority under the *Health Professions Act* to determine that general dentists are not permitted to administer dermal fillers. **Resolution** The dentist paid a $3,000 fine and signed an agreement not to administer or advertise dermal fillers, and to comply with CDSBC's bylaws and guidelines for advertising and promotional activities.
File 106	**Complaint** A patient complained that her tongue was cut during treatment and the dentist did not follow-up with her afterwards, and that she pulled her hair and did not apologize. **Investigation** The dentist saw the patient once for a specific exam about a broken tooth. The drill slipped during treatment and injured the patient's tongue, but the dentist said that she apologized and quickly stopped the bleeding using gauze. The dentist said that although she would never pull a patient's hair, she was eight months pregnant at the time and it was possible she accidentally touched the patient's hair as she leaned in to get a better view of the wound. The patient said the pain in her tongue grew worse after she left the dental office so she went to the hospital for pain medication. The hospital records provided by the patient confirmed a small puncture wound for which she received ibuprofen to manage the pain. CDSBC Investigators were concerned that the patient chart did not reference the injury. They also noted that the dentist had not addressed X-rays taken by a previous dentist, which showed evidence of decay on a number of teeth. The dentist said that she did not review those X-rays because the patient had attended for a specific exam. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and acknowledging CDSBC's expectation that all previous records be reviewed, even if the patient is attending for a specific exam.
File 107	**Complaint**

	A patient complained that implants placed by the dentist became repeatedly infected and had to be replaced twice. **Investigation** The dentist originally placed three implants but the patient experienced persistent infections that meant that they had be replaced twice. The dentist felt this was an unusual case and thought that the infections were due to a genetic or other outside factor. Both replacements were done by a specialist but paid for by the dentist at no charge to the patient. Before the second replacement, the patient wanted one of the implants restored with a crown. The dentist was concerned that this treatment option would not last for the long term because of the repeated infection. The dentist did not feel comfortable providing this treatment and referred the patient to the specialist for additional options. The records supported the dentist's treatment rationale and included a detailed consent form signed by the patient; however, the daily treatment notes were difficult to read and were missing some detail. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and read an article from the *Journal of Clinical Periodontology* which dealt with many of the issues encountered in this case.
File 108 Also see related: File 79	**Complaint** A patient complained that the dentist and his staff were unprofessional, as they did not provide her with the written treatment plan and cost estimate that was promised at her initial consultation. **Investigation** An extensive treatment plan involving removing teeth, placing 11 implants and dentures was discussed with the patient. It was estimated to cost $65-$85,000. The patient had to make multiple requests over several months before the office manager provided her with a written treatment plan. When it was finally received, it lacked detail and did not include any financial information. The dentist said that he relied on his office manager to provide this documentation to patients, but later learned the office manager was embezzling money. The office manager is now the subject of criminal proceedings.

	There was no concern with the treatment provided to the patient: the patient chart was thorough and showed that a good result was achieved, and the patient confirmed she is satisfied with the outcome. The dentist has sold his practice and now follows the informed consent protocols of the principal dentist at his new practice, which includes providing patients with detailed written treatment plans. **Resolution** The dentist signed an agreement to provide detailed written treatment plans and cost estimates to all patients prior to treatment, and acknowledged his responsibility to ensure that his staff's interactions with patients are professional and timely.
File 109	**Complaint** A patient complained about the care provided by his dentist of 28 years after his new dentist proposed an extensive treatment plan. **Investigation** The patient was concerned that his dentist was taking too many X-rays and switched to a new dentist. The new dentist proposed an extensive treatment plan, which made the patient wonder why his previous dentist did not identify and propose treatment for these same issues. The original dentist said that the patient had not expressed any concerns about excessive X-rays or anything else. He noted that he had referred the patient to another dentist to address concerns with his gums and he presumed the patient saw that dentist every year. The chart indicated the patient had not had his gums assessed since 2001. A review of the patient chart raised concerns that – contrary to the patient's concern – not enough X-rays were taken to allow the dentist to make a complete assessment of the patient's dental needs. Concerns about his recordkeeping and informed consent protocols, and his diagnosis and treatment planning were also noted. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, an X-ray interpretation course, a

	course focused on the diagnosis and treatment planning of periodontal and restorative concerns, followed by monitoring and chart reviews.
File 110	**Complaint** The parent of a teenaged patient complained about the dentist's treatment and billing practices. **Investigation** The dentist treated four teeth with fillings. The parent said that the treatment took less than half an hour to complete and exhausted his insurance coverage. The parent later took the child to another dentist who noted the fillings were incomplete and should be redone. The records provided by this dentist showed decay on all four teeth restored by the original dentist, along with other failing restorations. The insurer deemed two of the restorations incomplete and sent a letter to the dentist who did the fillings, requiring her to repay a portion of the treatment. The dentist disagreed with the opinion but did repay the money to the insurer. It did not appear that the dentist had misrepresented the treatment to the dental insurer. The complaint raised concerns about the dentist's competency. A random chart review revealed concerns in other areas of the dentist's practice. **Resolution** The dentist signed an agreement to a remedial program that includes: participation in a restorative study club; supervision of her crown and bridge dentistry until it is deemed acceptable; mentorship focusing on clinical diagnosis and treatment planning, operative dentistry techniques, endodontics, and complex multi-disciplinary restorative dentistry; and monitoring to track the dentist's compliance.
File 111	**Complaint** A patient complained that despite being told that all of the proposed treatment would be covered by his dental insurance plan, it was not, and that the dentist was dismissive when the patient raised the concern. **Investigation** The patient's insurer sent a pre-authorization to the patient (instead of to the dental office). The dentist asked the patient to bring it to his

	appointment, but he did not, so the office called the patient's insurer who said that it had been approved. The receptionist assumed that this meant all of the treatment would be covered by the patient's insurance plan and did not realize that the patient had already reached some of his limits for that year. The patient came to the dentist with a letter outlining his concerns. The dentist acknowledged that when this happened he was tired from a long day and did not handle the situation professionally. **Resolution** The dentist signed an agreement acknowledging the informed consent concerns raised in the complaint, confirming he had implemented a new protocol in his office to review pre-authorizations before starting treatment, and promising to address patient concerns in a courteous and empathetic way.
File 112	**Complaint** CDSBC opened an investigation into the standard of care being provided by a dentist after multiple concerns were noted in the course of a separate investigation. **Investigation** A review of 24 patient charts revealed concerns related to: gaps on crowns, which the dentist did not address (instead opting to monitor these teeth); problems with bridgework and restorative dentistry; informed consent; recordkeeping; and billing discrepancies (ethics). **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses and an ethics course. She also agreed to participate in 12 half-day mentoring sessions and in a clinical prosthodontics study club during a two-year period of monitoring that will include chart reviews.
File 113	**Complaint** CDSBC opened an investigation after a chart review in a separate investigation raised a concern that the dentist had not advised a patient when he saw evidence of deficient dental work. **Investigation**

	The dentist could easily see the gaps on several crowns that were visible in the X-rays that he took of the patient, but said that he did not mention them to the patient or record them in the patient chart because the crowns had been placed by a previous-treating dentist and because he was a new associate at the time. The dentist was told that he is expected to advise patients of any concerns with another dentist's treatment and record it in the chart. He advised CDSBC Investigators that he had already taken CDSBC's *Dental Recordkeeping* course. **Resolution** The dentist signed an agreement not to ignore any evidence of deficient dental work, even if it was done by another dentist.
File 114	**Complaint** CDSBC opened an investigation after a dentist's former patients contacted the College because he had not responded to their requests for their records. **Investigation** The dentist did not respond to CDSBC at first, but eventually contacted the Registration Department asking for a certificate of standing so that he could practise in Alberta. At that time, he said that his patients were aware he was relocating to Alberta and advised that he had now been in contact with his patients and was forwarding their dental records to them as requested. CDSBC contacted the patients who had initially complained and confirmed that they were now in possession of their records. CDSBC Investigators were concerned that the dentist's failure to provide his current contact information, and his delayed response to CDSBC had affected the continuity of care for many of his patients. **Resolution** The dentist signed an agreement to respond to CDSBC in a timely manner, always provide CDSBC with his current contact information, and take an ethics course. A monitoring file was opened to track the dentist's compliance.
File 115	**Complaint** A patient complained about the office's hygiene protocols, saying that at one appointment the dentist did not wear his gloves, and at another he

	wore his mask pulled down to his chin which allowed spit to fall on her face when he spoke. **Investigation** The dentist said that it is his protocol to wear gloves except on rare occasions. He said that he is aware of CDSBC's *Infection Prevention and Control Guidelines* and observes the appropriate hand-hygiene protocols, but did not dispute that he was not wearing gloves when he saw this patient. The dentist acknowledged that he often pulls his mask to his chin when speaking to patients so that they can hear him and that spit could have fallen on to the patient's face. **Resolution** The dentist signed an agreement to comply with CDSBC's *Infection Prevention and Control Guidelines* and to always wear a mask and gloves during dental procedures.
File 116 See File 130 for a related complaint the patient made about the general dentist referenced here.	**Complaint** A patient complained that she was not satisfied with the results after a year of orthodontic treatment she received from a specialist. **Investigation** The patient, who was previously a dentist herself in another country, was referred to the specialist by her general dentist for orthodontic treatment. The specialist prepared a treatment plan and discussed it with the patient, and said he advised her that a medication she was taking would affect the progress of her treatment. The specialist said the treatment progressed slowly but was moving according to plan until the patient became upset and discontinued the treatment. The patient had an open bite, but did not seem to understand that it would be addressed after the orthodontic treatment was complete and a planned implant was placed. The patient was also very concerned about a bent wire on her braces. The specialist told her it had likely bent with use and offered to fix or replace it, but she declined. The treatment plan was appropriate overall, but CDSBC Investigators felt that more detailed documentation could have prevented the patient's confusion and the deterioration of the dentist/patient relationship.

	Resolution The dentist signed an agreement to provide more detailed documentation of his orthodontic treatment plans to all of his patients.
File 117	**Complaint** A patient complained that a root canal done by the dentist failed and the tooth had to be extracted, and that she was billed for dental work that was not done. **Investigation** When the patient realized that some of the work had been billed for but not completed, she contacted her insurer. The patient said that $1,000 of treatment costs were billed to her insurance but not done. She was able to have the treatment covered under the care of another dentist. The dentist said that the billing issues were due to mistakes made by a new staff member. A review of the patient chart revealed concerns about the dentist's billing practices as well as his root canal treatment diagnosis and treatment planning. He often advised such treatment based on the possibility that the tooth would need it in the future, or completed root canal treatment before a tooth was crowned because it was easier to do. It appeared the patient had consented to much of the recommended treatment in the absence of a complete diagnosis, which raised concerns about the dentist's informed consent protocols. **Resolution** The dentist signed an agreement to cease providing root canal treatment until he successfully completes a hands-on course in endodontics, take an ethics course and CDSBC's *Tough Topics in Dentistry* course, a chart review and monitoring.
File 118	**Complaint** The parent of a 5-year-old patient complained that the dentist did not assess the patient's weight before treating her under light sedation. **Investigation** The patient was given one teaspoon of chloral hydrate followed by nitrous oxide at an appointment to restore two teeth. The dentist said that the father intervened in the treatment by continually touching and speaking with his daughter, which was distracting and unhelpful. The dentist reported that

	the patient had recovered normally from the treatment, but the father said that he and his daughter found the experience traumatic. A review of the patient chart did not raise a concern about the treatment; however, concerns were noted with the dentist's recordkeeping and informed consent protocols. There was no confirmation to support the dentist's assertion that he asked the mother for the patient's weight at an earlier appointment. The chart did include the types and amounts of sedative given, but did not include a separate sedation record, consent for sedation, or indicate whether the dentist used a tool that measures the oxygen in the patient's blood. To ensure that complete information is obtained and recorded, CDSBC's Complaint Investigators recommended that the dentist use a sample form provided by CDSBC to use for this purpose. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to review CDSBC's *Minimal and Moderate Sedation Standards.*
File 119	**Complaint** A patient complained that the dentist touched her chest four times during an appointment. **Investigation** The dentist saw the patient once for a hygiene appointment. He said the contact was unintentional and occurred as he was adjusting the bib, which had moved during treatment. He said he did not realize it had happened until the patient said something, at which time he apologized immediately and explained it had been accidental. He did not think that the patient appeared distressed so he continued the treatment. The dentist's explanation is confirmed by both the chart notations and his chairside assistant, who described him as kind and considerate of his patients' needs. The patient says she spoke with the dentist's assistant after the dentist left the operatory and was commended for speaking up for herself, leading her to believe this had happened before. She did confirm that the dentist apologized to her but was concerned enough to report the matter to the police.

	While there was no independent evidence to confirm exactly what happened, CDSBC was concerned about the dentist's conduct. The dentist no longer adjusts patients' bibs and understands that he should have taken the matter more seriously when the patient said something to him. **Resolution** The dentist signed an agreement to take a course on workplace communications and establishing healthy boundaries. A monitoring file was opened to track the dentist's compliance.
File 120	**Complaint** A dentist complained that another dentist's advertising and marketing was contrary to CDSBC's bylaws and guidelines for promotional activities. **Investigation** The dentist acknowledged that his websites contained content that was contrary to CDSBC's bylaws and guidelines for promotional activities and made changes to address each concern. As this was not the first time complaints have been made about the dentist's advertising activities, the matter was referred to the Inquiry Committee. **Resolution** The dentist was fined $3,000 and signed an agreement to ensure his promotional activities are in compliance with CDSBC's bylaws and guidelines for promotional activities.
File 121	**Complaint** A patient complained that she was charged for work that the dentist told her would be free of charge for the first year after her dentures were delivered. **Investigation** The patient returned for adjustments approximately 10 times in the months following the delivery of the dentures. She was not charged for these adjustments or a reline (material placed in a denture to keep it in place after bone loss) that was done to make the dentures fit better. The dentist said that her office generally covers these costs for the first three months, as opposed to the first year, and that the patient would not have been told otherwise. However, the patient's understanding was that the cost of any adjustments and two relines would be covered for the first year.

	The patient questioned whether the office should have billed the insurer for the second reline without her agreement. The patient also said that the reline material was cheap and the dentures were ill-fitting. The patient chart revealed the following concerns: • the chart did not include reference to any discussion with the patient about which costs would be covered for the first year; • the treatment plan lacked detail about the office's interactions with the patient (informed consent) and other treatments done for the patient; • many of the entries in the chart were not initialed; and • reline of the dentures that was done in the dental office was billed using the wrong code. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics* courses, and acknowledging CDSBC's expectation to use correct procedure codes when billing.
File 122	**Complaint** CDSBC opened an investigation after a pharmacist reported that the dentist impersonated a physician when he called to renew a prescription for himself. **Investigation** The dentist admitted that after his medication ran out he called the pharmacy himself using a physician's name rather than have the prescription renewed by a physician. The dentist apologized and expressed deep regret for his conduct. He also sent a separate explanation and apology to the physician. Because the medication in question is not a controlled substance and had little potential for addiction or abuse, CDSBC was satisfied that the public had not been put at risk by the dentist's conduct; however, CDSBC was concerned about the unethical conduct of the dentist. **Resolution** The dentist signed an agreement not to repeat the behavior and to attend an ethics course. Before the agreement was finalized, the dentist advised that he had sold his practice and withdrawn from the profession due to

	serious health issues. He advised he was unable to take the course and would not be returning to practice. The dentist died soon after that.
File 123	**Complaint** A patient complained about the aesthetics of crowns placed by the dentist and blamed serious complications following root canal treatment on antibiotics prescribed by the dentist. **Investigation** The dentist responded that the crowns were made according to the patient's specific requirements and were cemented with the patient's approval. The approval is not recorded in the chart and the patient disputed this (saying she was too ill to approve). The patient's complaints were not made for many weeks after the treatment. The post-treatment X-ray suggests that the root canal treatment was well done. Two other dentists who later saw the patient also said that the crowns were technically good but suggested that issues with the patient's bite may have contributed to her dissatisfaction. The dentist prescribed antibiotics when the patient returned with swelling and infection. The details of the prescription were not noted in the patient chart. She claims that the antibiotics made her very ill. **Resolution** The dentist signed an agreement to prescribe antibiotics judiciously, take CDSBC's *Dental Recordkeeping* course, spend a day being mentored by an endodontic specialist, and consider referring complex aesthetic cases to a specialist.
File 124	**Complaint** A pharmacist reported that the dentist self-prescribed a medication that should only be prescribed by a physician, as monitoring and blood tests are required to ensure safe and effective dosages. **Investigation** The dentist admitted he had self-prescribed thyroid medication several times in the year after moving to a new city. He said that he self-prescribed because he had not yet found a new physician to renew his prescription. The dentist was reminded that while his actions did not put the public at risk, it is inappropriate for dentists to self-prescribe medications for ongoing

	medical, non-dental conditions. The dentist agreed to make immediate arrangements to have his prescription reviewed by a physician and renewed by that physician, if necessary. **Resolution** The dentist signed an agreement that he would not self-prescribe medications that should only be prescribed by a physician.
File 125	**Complaint** A patient complained that a bridge provided by the dentist did not fit properly, and that the cost of treatment by another dentist to replace it would not be covered by his dental insurance. **Investigation** The patient said that when the dentist placed the bridge several years ago, it was too long and his teeth were ground down to make it fit. A different dentist later confirmed that one tooth was unsalvageable and that part of the bridge needed to be removed and replaced with a partial denture. The dentist who provided the bridge has not practised dentistry for several years due to a disability. He felt that responding to the complaint would be detrimental to his health and said it is very unlikely that he will return to practice as his chance of recovery is poor. **Resolution** The patient was advised that the investigation could not be completed at this time but will resume if the dentist ever applies to return to practice. The dentist acknowledged that if he wishes to return to practice, a condition of his reinstatement will be providing a substantive response to the complaint and participating in CDSBC's investigation.
File 126	**Complaint** A dentist complained that a treatment estimate provided to her patient by another dentist did not match the diagnosis and raised a billing concern. **Investigation** The dentist saw the patient at a clinic where she practises one day a week as an associate. Based on a quick clinical examination, she recommended that two teeth be root canal-treated. She noted that other teeth likely required restorations, but planned to confirm this when the patient returned for a complete new patient exam.

	The patient asked for an estimate of the proposed treatment and the front desk staff prepared it. The dentist did not review it with the patient. When the dentist saw it for the first time (after receiving the complaint) she said she was surprised at what was included but noted it was the office policy to base cost estimates on the worst case scenario. There were concerns with the dentist's informed consent and recordkeeping protocols. The dentist was advised that she should be aware of the information given to the patient, including the estimate, and that any concerns with what is being prepared by the front desk should be raised with the principal dentist. **Resolution** The dentist signed an agreement acknowledging the concerns, agreeing to take CDSBC's *Tough Topics in Dentistry* course, and confirming that she had already taken CDSBC's *Dental Recordkeeping* course after receiving the complaint.
File 127	**Complaint** CDSBC opened an investigation after the dentist failed to respond to requests (including reminder letters and phone calls) from CDSBC that were related to a separate investigation. **Investigation** The dentist said that when she received CDSBC's first letter she contacted her former dental office and was advised that she saw the patient in question once for a specific examination. The patient's regular dentist told her that he would respond on her behalf to CDSBC's inquiries. The dentist says she tried calling CDSBC twice, but there is no record of her calls and she acknowledged that she may have had the wrong number. CDSBC Investigators emphasized the need for her to respond to her regulator, even if her contact with the patient was limited and regardless of whether another dentist offered to do so on her behalf. **Resolution** The dentist signed an agreement to respond promptly to any future CDSBC communications that require a response.
File 128	**Complaint**

	CDSBC opened an investigation into the dentist's recordkeeping and diagnosis and treatment planning protocols after reviewing her records as part of a separate investigation. **Investigation** The dentist acknowledged keeping careless records, which lacked assessment of many aspects of the patient's oral status. Because the patient chart did not include complete information, it was not appropriate to bill the patient for a complete examination. The dentist agreed that she must ensure her billings correctly reflect the treatment provided and should take steps to improve her recordkeeping and diagnosis and treatment planning protocols. **Resolution** The dentist signed an agreement to review CDSBC's *Dental Recordkeeping Guidelines,* take CDSBC's *Dental Recordkeeping* course, ensure proper examinations are done and bill accordingly, take a X-ray technique course, and undergo a chart review and monitoring.
File 129	**Complaint** An insurer complained that it received dental claims listing the dentist as the treatment provider from offices in which she did not practise, and reported a delay in the dentist providing X-rays needed to verify a patient claim. **Investigation** The dentist owns 10 dental practices, but only practises at two of them. Her name was listed (by a receptionist) as the treating dentist for all 10 dental practices. The dentist clarified with all the offices that the name of the dental provider should be the name on the claim, and removed her name as a dental provider in the computer software for the offices where she does not practise. Regarding the delayed X-rays, the dentist provided these to the insurer directly. The insurer was satisfied and indicated it had no further concerns regarding billing or treatment. **Resolution** The dentist signed an agreement acknowledging the expectation that her billing accurately reflects the name of the treating dentist and the treatment provided.

File 130 See File 116 for a related complaint the patient made about the specialist referenced here.	**Complaint** A patient, who was previously a dentist herself in another country, complained that she was dissatisfied with many aspects of the treatment she received from the dentist, including failure to treat tooth decay, unprofessionalism, and poor recordkeeping. **Investigation** The patient asked for her chart when the dentist-patient relationship began to deteriorate after the dentist failed to successfully resolve her concerns with a specialist who was handling the orthodontic component of her treatment. In reviewing the chart, she noted several problems. The chart diagnosed decay on one tooth, which the dentist failed to restore. The dentist agrees with the diagnosis on the chart, but says that he told the patient he did not see evidence of decay. The dentist did not take an X-ray because the patient had brackets on her teeth. He agreed with CDSBC Investigators that pre-treatment X-rays should have been taken to confirm a diagnosis. The patient felt the dentist was being dishonest about the tooth decay and phoned him. The dentist hung up on her when the conversation became heated. He later told the patient the call ended because of a technical problem with his phone. The dentist admitted to CDSBC Investigators this was untrue and agreed that his behavior was unprofessional. The patient said that important information relating to her treatment was missing from her chart. CDSBC Investigators confirmed that the chart was incomplete: test results were not recorded and had not been shared with the patient or the specialist involved in her care. The dentist advised that since receiving the complaint he and his staff had taken CDSBC's *Dental Recordkeeping* course and that he had completed a number of courses focusing on diagnosis and treatment planning. **Resolution** The dentist signed an agreement acknowledging the concerns, confirming the continuing education courses that he had already taken to address them (and agreeing to provide formal confirmation of his successful completion).
File 131	**Complaint**

	A patient complained that his long time dentist failed to manage his decay or discuss preventive strategies with him. **Investigation** After several years of attending regular appointments, the patient stopped seeing the dentist, despite reminders from the office. The patient suffered a long-term injury and was on medication that caused dry mouth, contributing to his dental decay. The injury also left him with reduced insurance coverage, which is why he was no longer scheduling regular appointments. Years later, significant decay was noted when the patient had an emergency appointment to have two teeth extracted. The patient began seeing a new dentist, who confirmed that he had irregular dental care, a smoking habit, and consumed several sugary beverages a day, all of which contributed to the decay. The patient admitted that his original dentist had advised him to stop drinking sugary beverages. The dentist said that the importance of good home hygiene habits were discussed with the patient at every visit; however, details of these discussions were not included in the patient chart. The Complaint Investigator was concerned because the notes in the patient chart were limited primarily to the specific treatments provided, with no indication of clinical presentation, patient symptoms, or clinical diagnosis. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course.
File 132	**Complaint** A parent complained about the results of her son's wisdom tooth removal and orthodontic treatment. **Investigation** The parent said that her son had paresthesia (extended numbness and prickling/burning sensation) after two wisdom teeth were extracted. She felt that they had not been properly informed of the risks involved with the treatment. The dentist said the patient's parents did not report any post-operative problems, but the parents and patient disputed this. The patient chart showed that the orthodontic treatment achieved an acceptable result; however, another dentist later told the mother that re-treatment was required. The original dentist said that before beginning

	treatment he had advised that relapse was a possibility and that he had offered to re-do the treatment if needed. The parents dispute this, saying this was never mentioned. CDSBC Investigators were concerned that the patient chart did not reference informed consent discussions with the patient or his parents, which made it difficult to determine what actually occurred in this case. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses, and to standardize his orthodontic records.
File 133	**Complaint** An investigation was opened after CDSBC's Registration Department reported a concern that a dental student was practising dentistry before his student registration with CDSBC was finalized. **Investigation** The dental student admitted to the conduct and expressed embarrassment and shame, acknowledging that he was aware that his registration was not finalized and should have advised his supervising dentist that he should not be booked to see any patients during that time. **Resolution** During a meeting with CDSBC's Deputy Registrar, the student acknowledged the risk that his conduct presented to his supervisor and to patients. He signed an agreement not to hold himself out as a dentist or CDSBC registrant, or engage in the practise of dentistry until he is registered with CDSBC.
File 134	**Complaint** CDSBC's Registration Department reported a concern that a dentist was practising without professional liability insurance. **Investigation** The dentist had paid her insurance fees; however, she later learned the insurer had applied them to another account in error. The Registration Department advised the dentist that regardless of the error, she could not practise until her insurance was properly in place. The dentist confirmed that she did have a full day of patients booked, but after speaking with CDSBC, she cancelled them and did not treat any patients. She did,

	however, supervise a student, which she was not entitled to do in this circumstance. CDSBC Investigators were concerned that, even though the error made by the insurance provider was not her fault, the dentist did not understand why she was not permitted to practise. They advised the dentist that she is expected to understand her professional obligations. **Resolution** The dentist signed an agreement to ensure that she is aware of her professional responsibilities in the future.
File 135	**Complaint** An investigation was opened after an associate at the dentist's practice informed CDSBC that the dentist was not directly supervising a student practitioner as required. **Investigation** In the application for the student practitioner program, the dentist had indicated that she would supervise the student practitioner. She admitted that her associate dentist was supervising the student practitioner and that she had failed to notify CDSBC of the change in the reporting structure, contrary to the CDSBC Bylaws. **Resolution** The dentist was advised that she is expected to strictly adhere to the CDSBC bylaw that covers the responsibilities of the supervising dentist. The dentist signed an agreement that if she participates in the student practitioner program again, she will ensure any changes to the supervisory structure are reported to CDSBC immediately.
File 136	**Complaint** CDSBC investigated the dentist's root canal treatment diagnosis, treatment planning, and informed consent protocols after his records were reviewed as part of a separate investigation. **Investigation** The dentist was not able to attain complete anaesthesia (freezing) before replacing a patient's filling. He diagnosed the tooth pulp as dead, prescribed antibiotics and recommended the tooth be root canal-treated.

	Another dentist later saw the patient and advised that the first dentist may not have been able to attain complete anaesthesia due to infection and not because the tooth pulp was dead. The patient chart also suggested that the tooth pulp was not dead, which raised questions about the dentist's root canal treatment diagnosis and treatment planning protocols. **Resolution** The dentist signed an agreement to take a course on root canal treatment and CDSBC's *Tough Topics in Dentistry* course, and to undergo a chart review and monitoring.
File 137	**This complaint was addressed as a health file.**
File 138	**Complaint** Dentist A complained that Dentist B made negative comments to a patient about his associate's treatment plan, which caused the patient to demand a refund. **Investigation** Dentist A's associate saw the patient and developed a recommended treatment plan. The patient chart supports the treatment options that the associate provided to the patient. Dentist B told CDSBC Investigators that he did not make disparaging remarks about the associate; however, recordings of the conversations that Dentist A had with Dentist B and the patient suggested that he had criticized the associate's treatment plan. Dentist B's records suggest that he only gave the patient one option (extracting the tooth) when she should have also been given the option of root canal treatment and a crown. Dentist A attempted to discuss this with Dentist B over the phone. Dentist B said that the patient could not afford to pay for anything other than extracting the tooth and hung up. **Resolution** Dentist B signed an agreement acknowledging the concerns with his conduct, diagnosis and informed consent protocols, and agreeing to refrain from making disparaging remarks to patients about other dentists and to take CDSBC's *Tough Topics in Dentistry* course.
File 139	**Complaint**

	CDSBC investigated the dentist's recordkeeping and informed consent protocols based on concerns raised during a separate investigation. **Investigation** The patient chart did not support the extensive treatment plan, and showed that not all treatments had been included in the cost estimate that was given to the patient. The dentist said that she had several detailed informed consent discussions with the patient, but these discussions were not noted in the chart. The dentist currently practises in another province but said that she now takes much more detailed records and was open to the feedback on her recordkeeping and informed consent protocols. **Resolution** The dentist signed an agreement acknowledging the concerns with her recordkeeping and informed consent protocols and agreeing that if she returns to practice in B.C., she will take CDSBC's *Dental Recordkeeping* and *Tough Topics in Dentistry* courses.
File 140	**Complaint** An investigation was opened when CDSBC's Registration Department became aware that a dentist did not contact CDSBC to change her registration category when her studies ended and she began a job as a lecturer and clinical supervisor. **Investigation** When her post-graduate studies ended, the foreign-trained dentist accepted a position at an educational facility as a lecturer and clinical supervisor. The position was not covered by her registration category. She said that she had called CDSBC and was told she could accept the position with her current registration category, though she did not know who she spoke to. The Registration Department's policy is to document all conversations with registrants in a database, yet there is no record of this call. A few months later, when another employment opportunity arose, she emailed CDSBC to enquire about changing to an academic registration category. At this time, CDSBC realized that she had been practising without the appropriate registration category and that she did not have professional liability insurance. Her registration was immediately cancelled.

	The dentist felt the situation was a result of miscommunication and misinformation, as she believed she had appropriate registration and insurance coverage. CDSBC's Investigators noted that when she initially was granted registration, CDSBC advised (in a letter) that her registration was only available to her for the duration of her studies. CDSBC Investigators were concerned that she did not understand her professional obligations. **Resolution** The dentist signed an agreement acknowledging her professional responsibility to conduct herself in accordance with the CDSBC Bylaws and Code of Ethics and that she understands her obligations (if she applies for reinstatement) to renew her registration and professional liability insurance coverage annually.
File 141 Also see related: File 87 & File 142	**Complaint** CDSBC opened an investigation after learning that a dentist gave conflicting reports of a diagnosis during the course of a separate complaint investigation. **Investigation** The dentist saw the patient for a new patient exam after another dentist had previously diagnosed decay on three teeth. The dentist initially said there was no evidence of decay but later said that the X-ray showed evidence of decay on two teeth. He said that he could not contact the dentist who had diagnosed decay on three teeth to discuss this because he did not know who she was. The dentist later signed a statement prepared by the patient's father, which said the patient had no decay in any of her teeth. The father then used this signed statement in a complaint that he made against the dentist who had previously seen the patient. The statement created complications for the other investigation because CDSBC Investigators agreed that there was, in fact, decay on three teeth visible on the X-ray (as had been diagnosed by the first dentist). When asked about the inconsistencies, the dentist said that while there was no clinical evidence of decay, there was X-ray evidence of early decay. He said he planned to monitor the early decay for six months and discussed this with the patient; however, this is not recorded in the patient chart.

	Resolution The dentist signed an agreement to take an ethics course, CDSBC's *Dental Recordkeeping* course and a course on diagnosing decay.
File 142 Also see related: File 87 & File 141	**Complaint** CDSBC opened an investigation after the dentist self-reported (during investigation of File 87) that she had altered a date in the patient chart so that the patient could make an insurance claim when the treatment would be covered. **Investigation** The dentist confirmed she had changed the date in the patient chart to make it seem as if a denture was delivered nine months after it was actually inserted. The dentist said she made the change because she was intimidated by the patient who pressured her to maximize his insurance coverage. The dentist agreed this did not excuse her conduct. She contacted the insurance company to self-report her error and reimbursed it for the costs. **Resolution** The dentist signed an agreement to take CDSBC's *Dental Recordkeeping* course and a course titled *Asserting Yourself in Conflict Situations*.